

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12001</u>	
BIRTH NO. <u>66 12001</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Joseph Curreri</u>		2. DATE AND HOUR OF DEATH <u>Nov. 29, 1966</u> <u>1 1.07 P. M.</u>	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>3126 Woodhome Ave.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #34</u> <u>27-05</u>			
		D. STREET ADDRESS (If rural, give location) <u>3126 Woodhome Ave.</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>Jan. 29, 1910</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fruit &amp; Produce</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Carmelo Curreri</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Cimmino</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-14-8249</u>		17. INFORMANT <u>Madeline Curreri</u>	
				ADDRESS <u>same</u>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Carcinoma of the left lung</u> DUE TO  (B) _____ DUE TO  (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12. 17</u> <u>1965</u> to <u>11. 29. 66</u> <u>19</u> , that (I) (we) last saw the deceased alive on <u>11. 29.</u> <u>1966</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11. 29. 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR Jos. SKLOVEN</u>		23D. ADDRESS <u>7122 Harford Rd, Balto 34 md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>12/3/66.</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Red. Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>Edward J. Buck Inc Baltimore, Md.</u>	
				ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
M.E. CASE NO.				66 12002				66 12002			
1. NAME OF DECEASED (Type or Print)				SIMON N. SEIDL				2. DATE AND HOUR OF DEATH Nov. 30, 1966 12:45 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland				B. COUNTY			
5770 Maple Hill Road				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #14 27-38							
D. STREET ADDRESS (If rural, give location) 5770 Maplehill Road											
5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH Dec. 6, 1892		9. AGE (In years lost birthday) 73		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector retired				10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co. of Baltimore				11. BIRTHPLACE (State or foreign country) Perry Hall, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Barthlo Seidl				14. MOTHER'S MAIDEN NAME Mary Schott							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1				16. SOCIAL SECURITY NO. 212-07-6148				17. INFORMANT ADDRESS Mrs. Simon N. Seidl--5770 Maplehill Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Acute Myocardial Infarction ASC & D (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 1 day year			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 19 65 to Nov 30 19 66, that (I) (we) lost saw the deceased alive on Nov 16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE George H. Beck				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 11/30/66			
23C. PHYSICIAN'S NAME (Type) Dr. George H. Beck				23D. ADDRESS 6012 Harford Rd., Baltimore, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/66.		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1966		25B. NAME OF REGISTRAR E. J. Feltman		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--5305 Harford Rd., Baltimore, Md.		ADDRESS					

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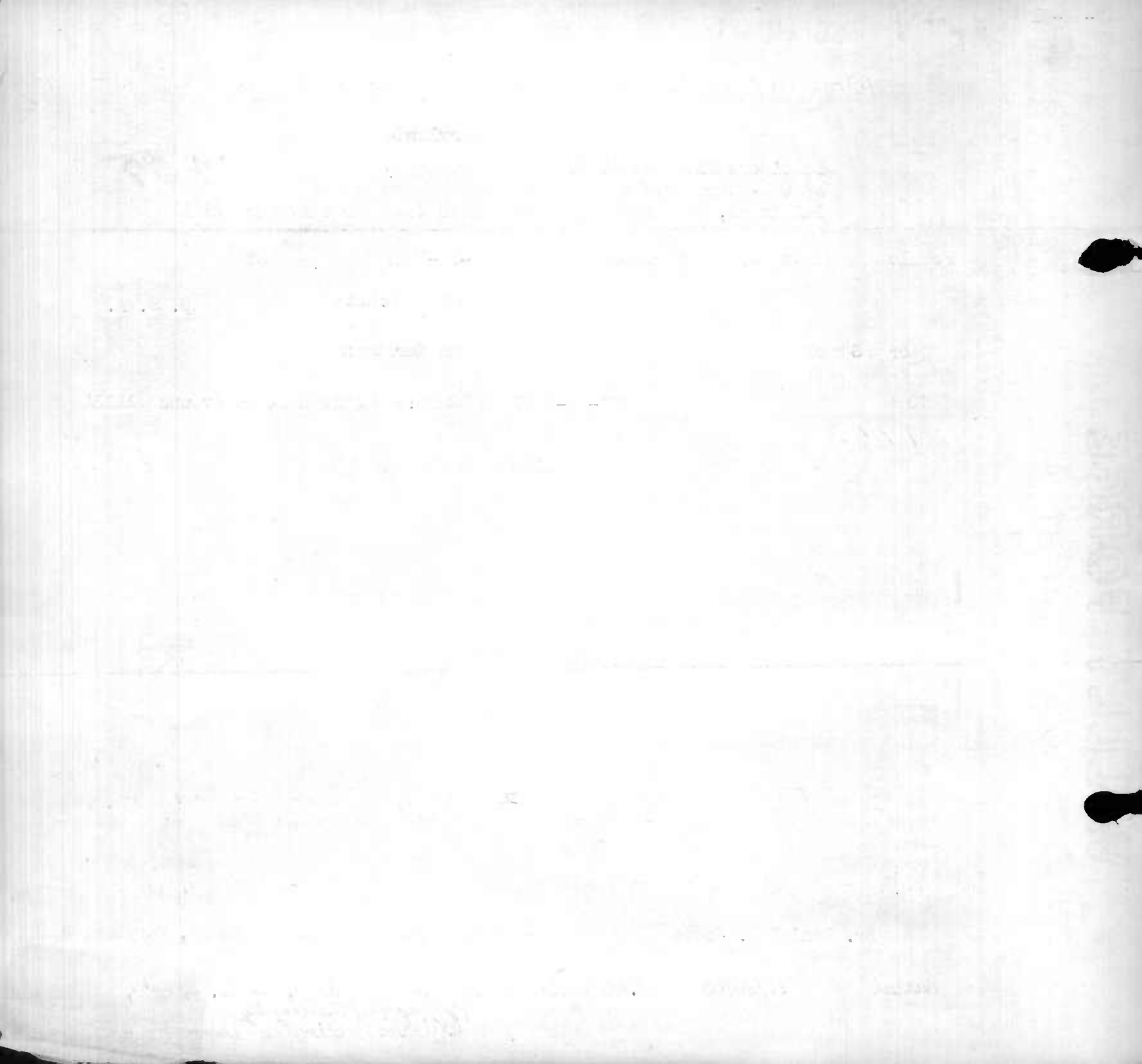
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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12003	
BIRTH NO. 66 12003				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED	
1. NAME OF DECEASED (Type or Print) MARMION R. RIDGELL				2. DATE AND HOUR OF DEATH 24 NOVEMBER, 1966 2:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1280 Woodbourne Avenue 21212	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-14-1917	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Dakota	
13. FATHER'S NAME George Shuck			14. MOTHER'S MAIDEN NAME Rena Horstman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 501-05-6687		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				8 MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 22 AUGUST, 1966 to 24 NOVEMBER, 1966, that (I) (we) last saw the deceased alive on 24 NOVEMBER, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel D. Foote				23B. DATE SIGNED 24 NOVEMBER, 1966	
23C. PHYSICIAN'S NAME (Type) Dr. Daniel D. Foote				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/26/66		24C. NAME OF CEMETERY or CREMATORY St. Michaels Cemetery Ridge, St. Mary's, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. NOV 30 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. NAME OF FUNERAL DIRECTOR W. Clarke Mattingley		25D. ADDRESS Leonardtown, Maryland			



D-635

66 12004

BALTIMORE CITY HEALTH DEPARTMENT

66 12004

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SHELIA

DARDEN

2. DATE AND HOUR PRONOUNCED DEAD

November 30, 1966

2:00 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

**CERTIFICATE AMENDED**  
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL OR ADDRESS OR LOCATION)  
INSTITUTION

12-5-66

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2644 Edmondson Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

December 25, 1957

9. AGE (in years  
lost birthday)

-9 11 yrs.

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Clarence Darden

14. MOTHER'S MAIDEN NAME

Elizabeth Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

Elizabeth Darden  
2644 Edmondson Ave Mother

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Craniocerebral Injury.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Braddish &amp; Rayner Avenues

21D. TIME  
OF INJURY  
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

(Min.)

11

29

'66

P

m.

21E. INJURY OCCURRED

WHILE AT  
WORK

AT

NOT WHILE  
AT WORK

X

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/30/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-3-66

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

DEC 1 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Examining Wright  
2700 Edmondson Ave

ADDRESS

V.S. 153

12-5-66

M.H.

VALLEY FORD

OFFICE

1  
A-42

66 12005

BALTIMORE CITY HEALTH DEPARTMENT 17-16-0785

66 12005

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		MARGARET ALSUP		2. DATE AND HOUR PRONOUNCED DEAD November 27, 1966   2:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 43/99 South Baltimore Hospital (DOA)				A. STATE Maryland	
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-32	
				D. STREET ADDRESS (If rural, give location) 3016 Ascension Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 10-2-1896	9. AGE (In years last birthday) 71	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Emma Burts		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT Audrey Howard 2904 Demham Circle		
			ADDRESS		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED November 28, 1966	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 10-1-66		23C. NAME OF CEMETERY or CREMATORY Mt Calvary	
23D. LOCATION A.A.C., MD		23E. LOCATION (City, town, or county) (State)			
24A. DATE REC'D BY HEALTH DEPT. DEC 1 1966		24B. NAME OF REGISTRAR A. C. E. Johnson		24C. FUNERAL DIRECTOR L. B. Brown	
24D. ADDRESS		24E. ADDRESS		24F. ADDRESS	



WALLER FORMER

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12006</b>	
BIRTH NO. <b>66 12006</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CRIST, MR MARTIN</b>		2. DATE AND HOUR OF DEATH <b>11-26-1966 12:40 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 6-02</b>	
		D. STREET ADDRESS (If rural, give location) <b>22 Northport St. (24)</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>9. 11. 1913</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintainence</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork Seal</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMER.</b>		13. FATHER'S NAME <b>Martin Crist (Krystofiak)</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH MURPHY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-10-6267</b>		17. INFORMANT <b>DR. M. SALEEM</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of The recto-sigmoid</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>metastases to The liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 months aproximately</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>AsThenia malnutrition</b>			
19A. DATE OF OPERATION <b>15-2-1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ca recto-sigmoid</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-10-1966</b> to <b>11-26-1966</b> , that (I) (we) last saw the deceased alive on <b>11-26-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Saleem</b>				23B. DATE SIGNED <b>11-26-1966</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-30-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>		25B. NAME OF REGISTRAR <b>John C. Miller Inc.</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>6415 Belair Road-21206</b>					

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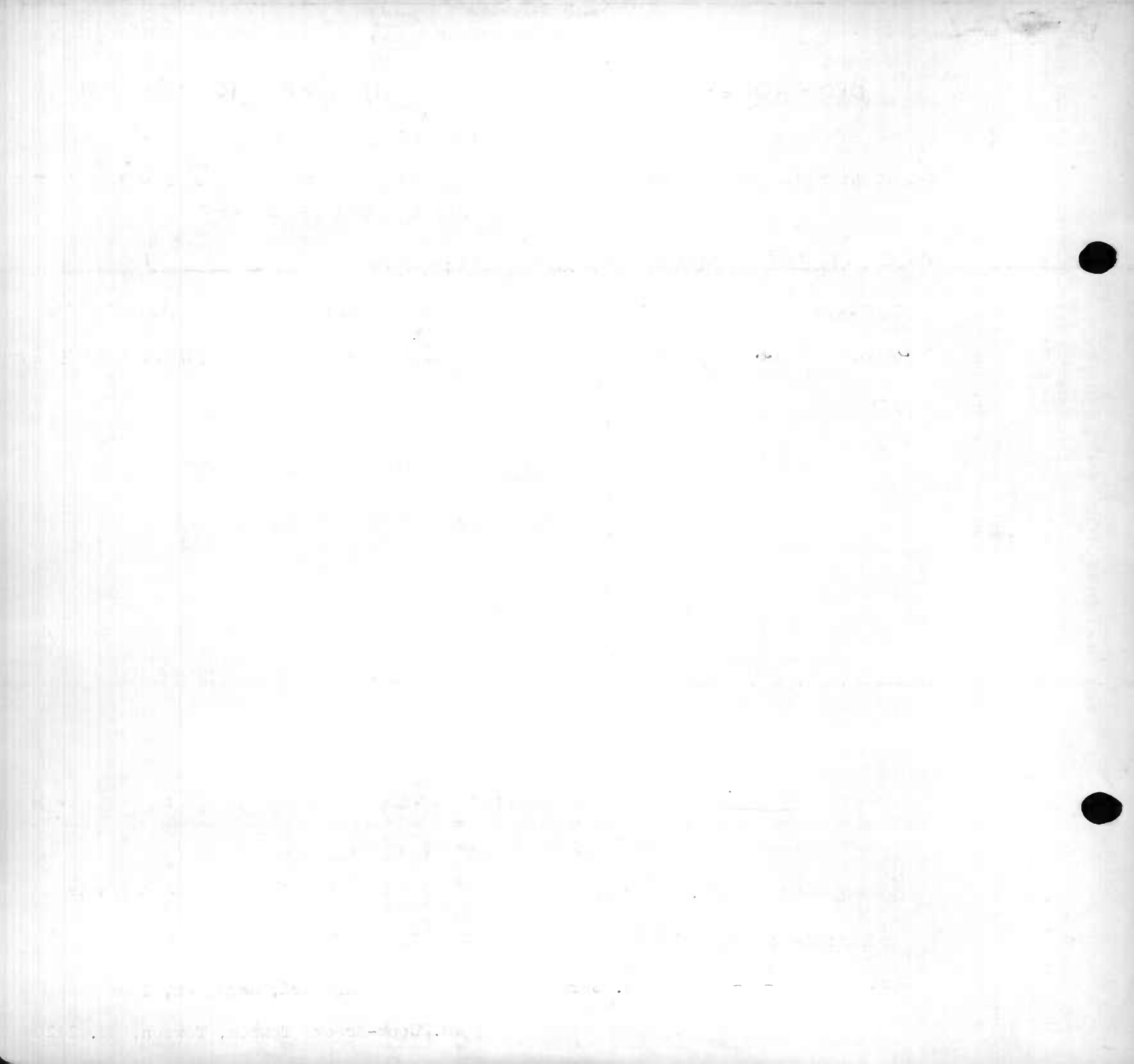
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12007 7</u>	
BIRTH NO. <u>66-25531 66 12007</u>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>BROOK HOUSER, BABY BOY</u>			2. DATE AND HOUR OF DEATH <u>11/27/66 10:45 PM</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
			D. STREET ADDRESS (If rural, give location) <u>611 N CAROLINE STREET</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>11/26/66</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>
13. FATHER'S NAME <u>PATRICK BROOK HOUSER</u>			14. MOTHER'S MAIDEN NAME <u>JUDITH</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT ADDRESS <u>611 N CAROLINE ST</u>
18. <u>762.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Apnea at delivery cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Possibly due to placental insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>11/26/66</u> 19 <u>66</u> to <u>11/27</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/27/66 10:45 PM</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) (did not) view the body after death.					
23A. SIGNATURE <u>Elizabeth Maxwell</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/27/66</u>
23C. PHYSICIAN'S NAME (Type) <u>Elizabeth Maxwell</u>			23D. ADDRESS <u>The Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-30-66</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt. Carmel</u>		24D. LOCATION (City, town, or county) (State) <u>Missouri, Harrison, Iowa</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 86 12008		CERTIFICATE OF DEATH		Registered No. 66 12008	
1. NAME OF DECEASED (Type or Print) <b>Anna Estremoky</b>				2. DATE AND HOUR OF DEATH <b>11/28 66 11 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital Calvert &amp; 33rd Street, Baltimore</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Md 21222 53-00</b> D. STREET ADDRESS (If rural, give location) <b>2413 Fairway - Dundalk.</b>					
5. SEX <b>F</b>	6. RACE <b>White</b>	7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify))		8. DATE OF BIRTH <b>12 08 36</b>	9. AGE (In years last birthday) <b>30</b>	10. CITIZEN OF WHAT COUNTRY? <b>10 28</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Charles Dehoff.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Charles Dehoff</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>219-305074</b>		17. INFORMANT <b>JOSEPH S. ESTREMSKY</b>		ADDRESS <b>Dundalk</b> <b>2413 Fairway</b>	
18. I <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Carcinoma of Breast w metastases</b> (B) <b>metastases</b> (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>April 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Breast</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from <b>11/1 1966</b> to <b>11/28 1966</b> , that (we) last saw the deceased alive on <b>11:25 am 11/28 1966</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Robert P. Doyle</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>11/28/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>ROBERT P. DOYLE</b>						23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/1/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Louclon Park</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO-Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Baltimore</b>		25C. FUNERAL DIRECTOR <b>F. B. Nippert</b>		ADDRESS <b>1300 EUTAW PI</b>			

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Robert P. Doyle

Robert P. Doyle

Robert P. Doyle

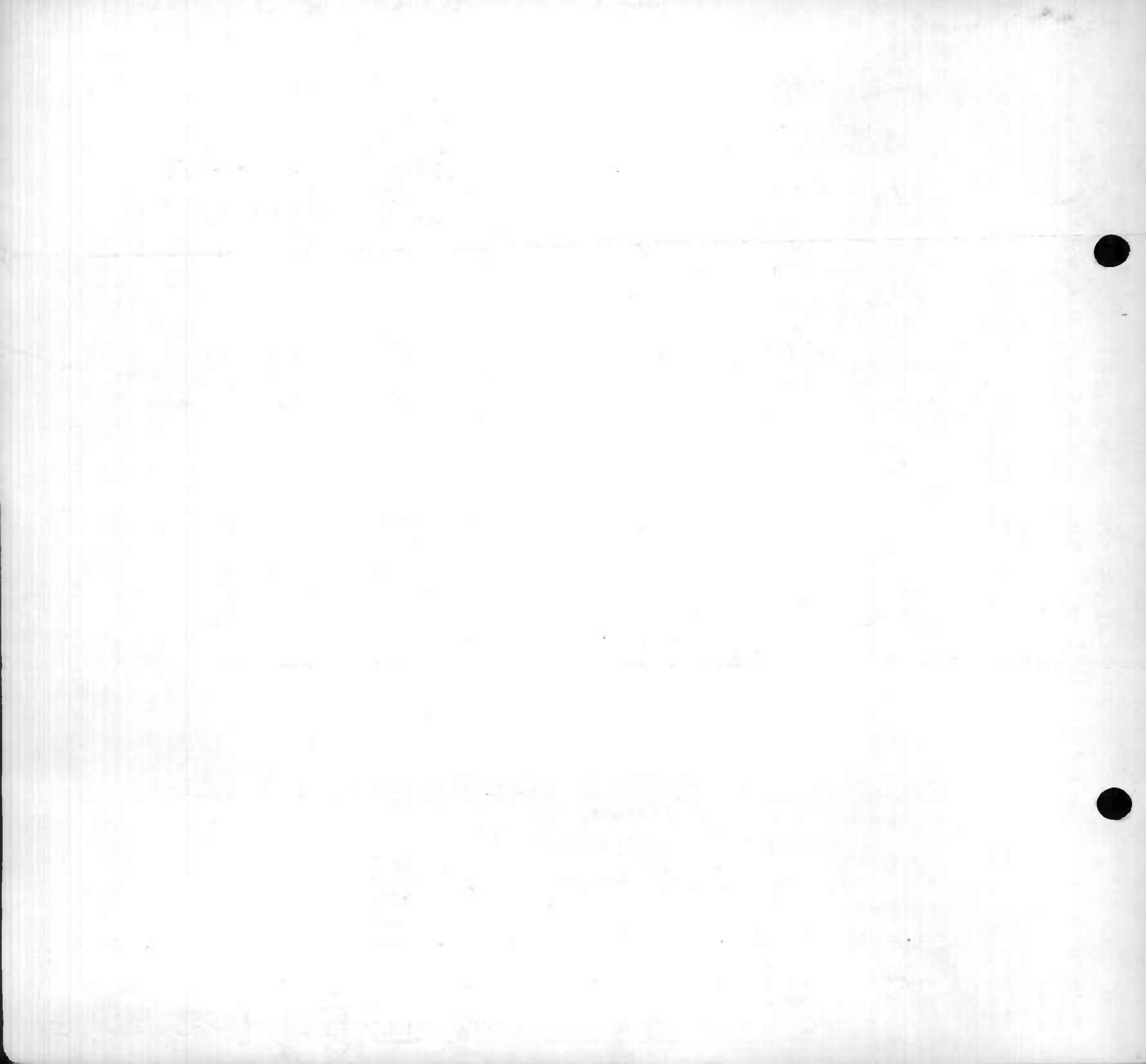
Robert P. Doyle



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12009				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12009	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Lewis H. SAMM</i>		2. DATE AND HOUR OF DEATH <i>11/28/66</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>337 Hocking St.</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MD.</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write PARAL and give township) <i>Baltimore 3-01</i>			
				D. STREET ADDRESS (If rural, give location) <i>337 Hocking St.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>9-95</i>	9. AGE (In years lost birthday) <i>71</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cooper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Buckel Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Lewis H.</i>				14. MOTHER'S MAIDEN NAME <i>Leonora</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family - Same</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.171 260X</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>Coronary Thrombosis</i> DUE TO		<i>several hours</i>	
				(B) <i>Arterio sclerotic heart disease</i> DUE TO		<i>3 years</i>	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>Diabetes Mellitus</i>		<i>4 years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9-11-63</i> to <i>11-28-66</i> and that (I) (we) last saw the deceased alive on <i>November 4th</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Harry Deibel</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>Dr. Harry Deibel M.D.</i>				23D. ADDRESS <i>1226 S. Hanover Street Balto Md. 21230</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12/2/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill</i>		24D. LOCATION (City, town, or county) (State) <i>Balt.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Gray &amp; Sons</i>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12010		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12010	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BABY NEWBORN ALSTON</b>		2. DATE AND HOUR OF DEATH <b>11/23/66 6:00 P.M.</b>	
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Bow Md</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours HOSPITAL</b> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO 16-08</b>			
		D. STREET ADDRESS (If rural, give location) <b>3651 Gelsston DR</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>11-22-66</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min. <b>1 10 50</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Herbert Alston</b>		14. MOTHER'S MAIDEN NAME <b>Jean Reed</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Jean Reed</b> ADDRESS <b>3651 Gelsston Drive BALTO. 29</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Anoxia</b> (B) <b>Hyaline Membrane Disease</b> (C) <b>Immaturity</b>		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>11/23 19 66</b> to <b>11/23 19 66</b> , that (I) (we) last saw the deceased alive on <b>11/23 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Chang B. Bae</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/23/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Chang Bae BAE</b>		23D. ADDRESS <b>Bon Secours Hospital</b>			
24A. BURIAL/CREMATION, REMOVAL (Specify)		24B. DATE <b>11/26/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Peter's Cem</b>	
24D. LOCATION (City, town, or county) <b>BALTO MD</b>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <b>DEC 1 1966</b>	
24G. NAME OF REGISTRAR <b>Thomas J. Kelly Jr</b>		24H. FUNERAL DIRECTOR <b>Thomas J. Kelly Jr</b>		24I. ADDRESS <b>BALTO MD</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
66 12011					CERTIFICATE OF DEATH					Registered No. 66 12011									
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) Chesno, Vincent John, Sr.					2. DATE AND HOUR OF DEATH 11-27-66 12:02 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Baltimore, Maryland					(If not in hospital or institution, give street address or location)					A. STATE Maryland					B. COUNTY				
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-04									
										D. STREET ADDRESS (If rural, give location) 2100 Frederick Avenue									
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 6-30-1914		9. AGE (In years last birthday) 52		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant				10B. KIND OF BUSINESS OR INDUSTRY Self				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Chesno										14. MOTHER'S MAIDEN NAME Katherine Zolenas									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 213-01-1974					17. INFORMANT ADDRESS Mrs. Antanina N. Chesno, 2100 Frederick Ave.									
18. I 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) DUE TO Coronary occlusion (B) DUE TO Coronary insufficiency (C) - angina					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 1966 to Nov. 27 1966, that (I) (we) last saw the deceased alive on Nov 27 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Stanley Ankudas										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 11.29.66.				
23C. PHYSICIAN'S NAME (Type) Stanley Ankudas										M.D. 23D. ADDRESS 1101 Maiden Choice Lane, Balto., Md. 21229									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 11-30-66					24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1966					25B. NAME OF REGISTRAR Howard H. Hubbard					25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue 21229									

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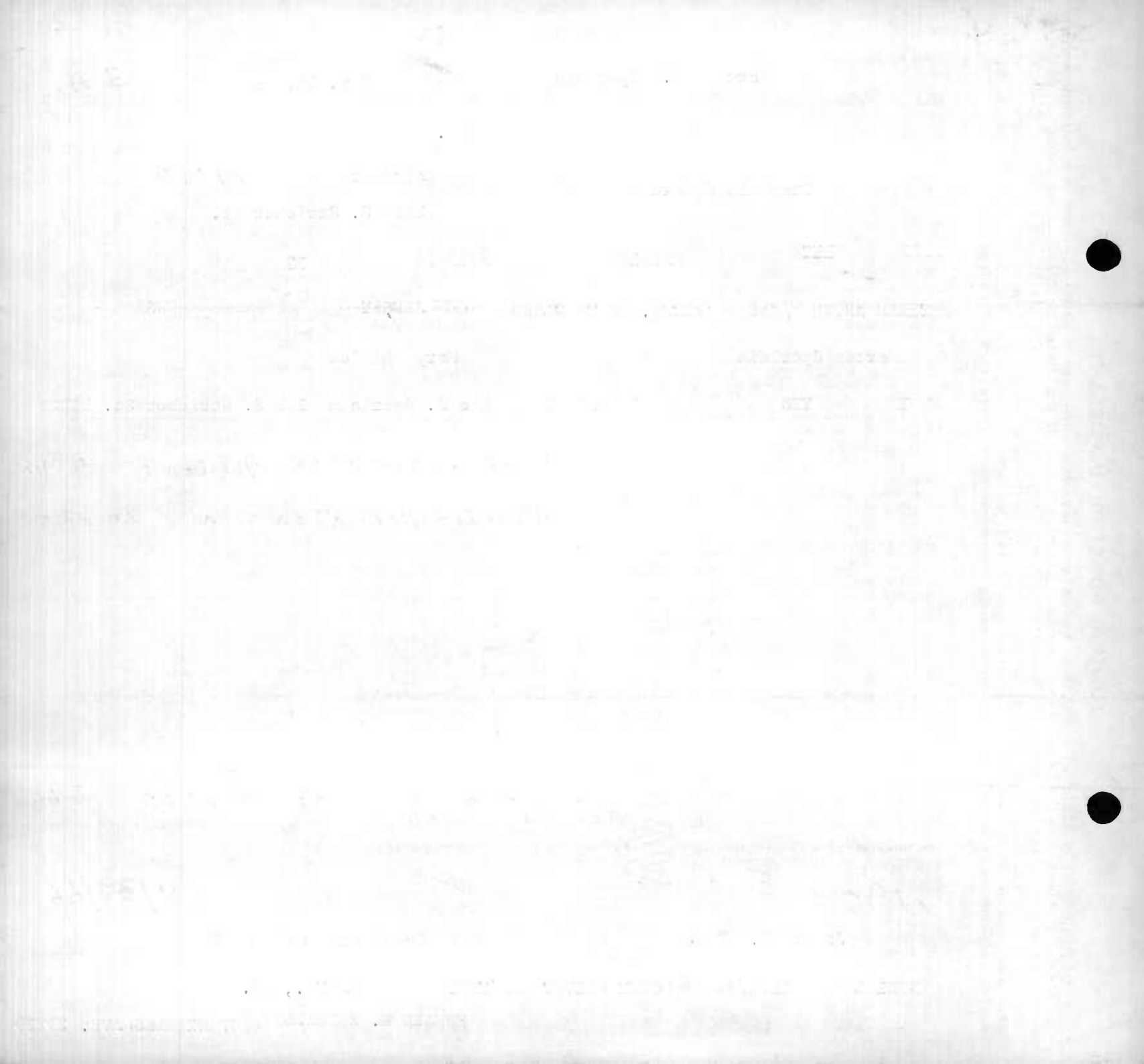
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 12012	
BIRTH NO. 66 12012				CERTIFICATE OF DEATH	
M.E. CASE NO.				Registered No. 66 12012	
1. NAME OF DECEASED (Type or Print) <b>Martin H. Sperlein</b>			2. DATE AND HOUR OF DEATH <b>Nov. 28, 1966</b> <b>3 A.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>36 Franklin Square Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>212 S. Stricker St.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5/15/94</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BRUSH MAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PITTS. PLATE GLASS</b>		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Martin Sperlein</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Linice</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW I YES</b>		
16. SOCIAL SECURITY NO. <b>213053005</b>			17. INFORMANT ADDRESS <b>Eva J. Sperlein 212 S. Stricker St. 21223</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>443 XI</b> <b>CEREBRO VASCULAR ACCIDENT 5 MIN</b> <b>ASCVD + HYPERTENSION 20 YRS.</b>			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>AUG 5 1963</b> to <b>Nov 28 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 24 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James E. Rowe</b> M.D.				23B. DATE SIGNED <b>11/29/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>James E. Rowe</b> M.D.				23D. ADDRESS <b>5550 Baltimore National Pike</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/1/66</b>		24C. NAME of CEMETERY or CREMATORY <b>MOUNT OLIVET CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>		25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HOWARD H. HUBBARD 4107 WILKENS AVE. 21229</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12013				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12013	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Bertha A Harden</b>				2. DATE AND HOUR OF DEATH <b>November 28, 1966</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 Anderson Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3714 Mohawk Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>2-2-1882</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Harden</b>			14. MOTHER'S MAIDEN NAME <b>Mary Grimes</b>		17. INFORMANT ADDRESS <b>Helen Harden 5301 Wesley Avenue # 7</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>219-30-8844</b>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRO VASCULAR ACCIDENT</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSIVE ART. CV DISEASE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 HOURS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>10-4-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 3 1966</b> to <b>Nov 28 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 28 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.							
23A. SIGNATURE <b>Kennard Yaffe</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Nov. 29 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>KENNARD YAFFE</b>				23D. ADDRESS <b>5501 Forest Park Ave Baltimore Md 21207</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-1-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>...</b>		ADDRESS <b>4600 Liberty Hghts. Ave. # 7</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12014		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12014	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Elizabeth Ford		2. DATE AND HOUR OF DEATH 28 Nov 1966 8 30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1212 DUKELAND STREET #21216			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 3-30-96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Amhurst Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME BALLY WATKINS			14. MOTHER'S MAIDEN NAME ANGELINE LANDRUM		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 229-40-2586	17. INFORMANT ADDRESS BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Acute Renal Failure (B) DUE TO Dehydration (C)		INTERVAL BETWEEN ONSET AND DEATH 5 days 5(+ ) days	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Ca of Pancreas		? 1 yr.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 7 Nov 1966 to 28 Nov 1966, that (we) last saw the deceased alive on 28 Nov 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dudley A. Raine Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 28 Nov 1966		
23C. PHYSICIAN'S NAME (Type) DUDLEY A. RAINE JR.		M.D.	23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-2-66	24C. NAME OF CEMETERY or CREMATORY Timothy Baptist		24D. LOCATION (City, town, or county) (State) Pleasant View, Virginia	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Carl Hutcherson - Lynchburg, Virginia	

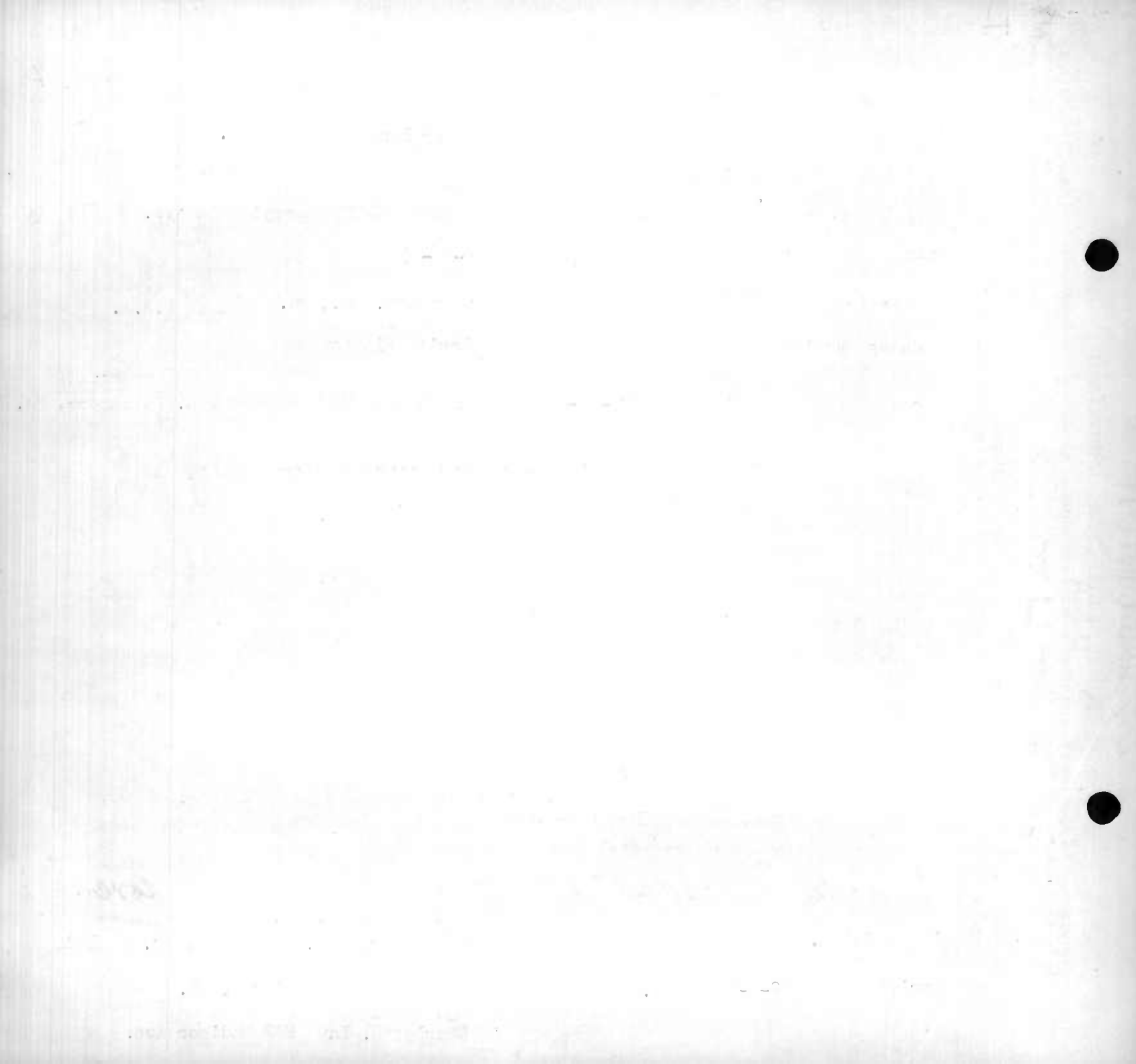
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

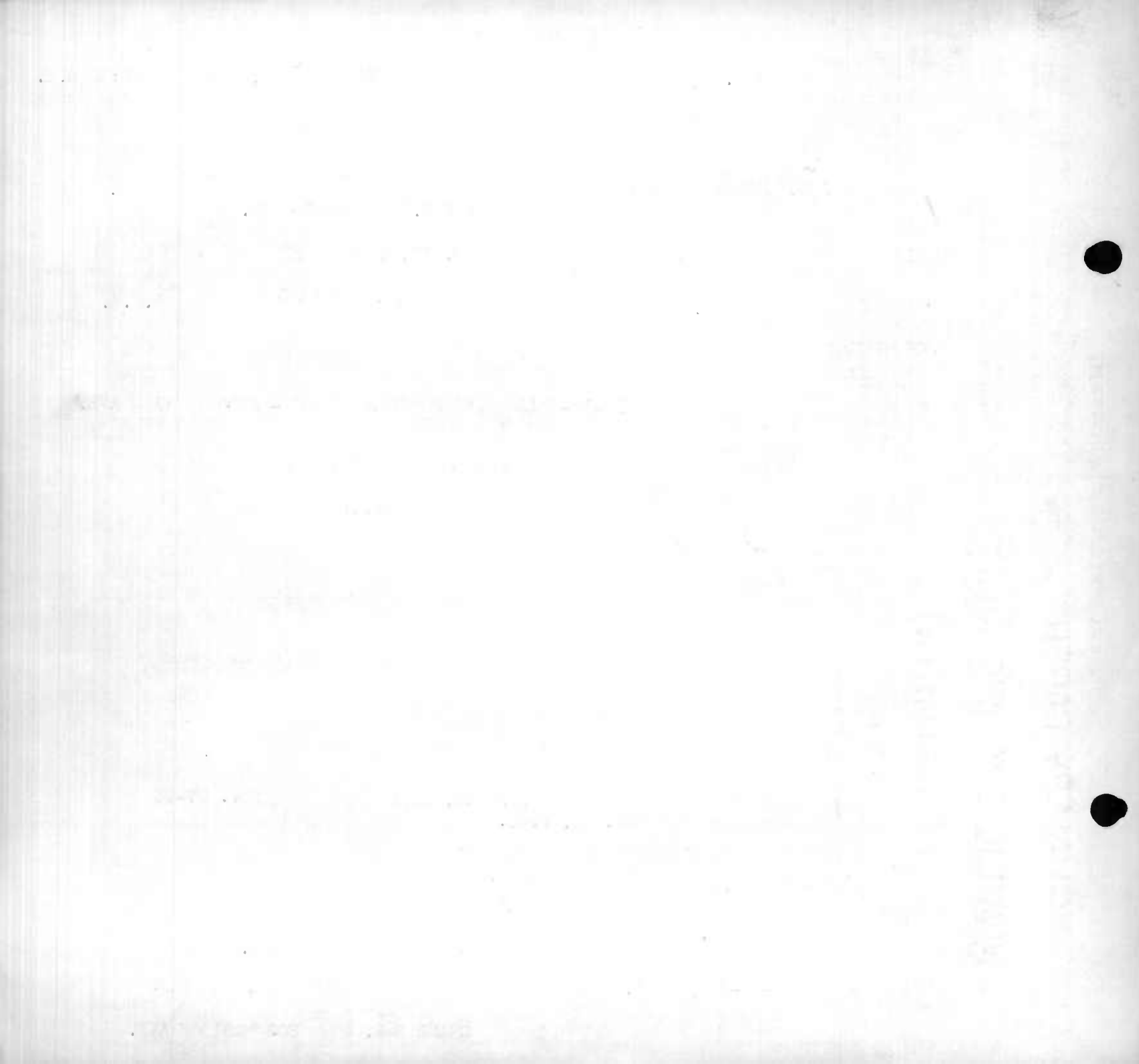
48-18-50 ED		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12015	
<div style="display: flex; justify-content: space-between;"> <span>66 12015</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>BIRTH NO.</b> M.E. CASE NO.		<b>1. NAME OF DECEASED</b> (Type or Print) <u>SAMUEL HAWKINS</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>26 NOVEMBER 1966 410 P.M.</u>	
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Maryland # 21224</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>14-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2043 Pennsylvania Ave. #21217 007</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. RACE</b> <u>Negro</u>	<b>7. MARRIED, NEVER MARRIED</b> <u>WIDOWED, DIVORCED (specify)</u> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>12-25-75</u>	<b>9. AGE</b> (In years last birthday) <u>90</u>	<b>10. Under 1 Yr.</b> Months: Days: Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Prince Geo. Co., Md.</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>James Hawkins</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Louise Pinkney</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>579-05-4724</u>		<b>17. INFORMANT</b> <u>BCH: Records 4940 Eastern Ave. Baltimore, Md.</u>	
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Active Tuberculosis Lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
<b>19A. DATE OF OPERATION</b> <u>2</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>YES</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 25 NOVEMBER, 19 66 to 26 NOVEMBER, 19 66, that (I) (we) last saw the deceased alive on 26 NOVEMBER, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Daniel D. Foote</u> M.D.				<b>23B. DATE SIGNED</b> <u>26 November, 1966</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Daniel D. Foote</u>				<b>23D. ADDRESS</b> <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. # 21224</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>12-1-66</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Mt. Auburn</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 1 1966</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Charles R. Law</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Charles R. Law 802 Madison Ave.</u>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12016		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12016	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		EMILY E. JENNINGS		2. DATE AND HOUR OF DEATH NOVEMBER 26, 1966 8:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		MARYLAND	
822 N. CARROLLTON AVENUE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		822 N. CARROLLTON AVE.	
5. SEX FEMALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH SEPT. 13, 1884	9. AGE (In years lost birth day) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME JOHN BOYER		14. MOTHER'S MAIDEN NAME EMILY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-12-6848		17. INFORMANT MARJORIE JENNINGS - 4009 BELVIEW AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardiovascular Disease DUE TO Arterio Sclerosis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ? ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 15, 1966 to Nov. 27-66 that (I) (we) lost saw the deceased alive on Nov. 26, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William R. Johnson				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) WILLIAM R. JOHNSON		23D. ADDRESS 403 Medical Arts Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-30-66		24C. NAME of CEMETERY or CREMATORY MT. AUBURN	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1966		25B. NAME OF REGISTRAR W. R. Johnson		25C. FUNERAL DIRECTOR CHARLES R. LAW	
				ADDRESS 802 MADISON AVE.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 12017		CERTIFICATE OF DEATH		66 12017	
1. NAME OF DECEASED (Type or Print) <b>Roy Miller</b>			2. DATE AND HOUR OF DEATH <b>11/29/66</b> <b>8:00 A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The JOhns Hopkins Hospital</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>7-04</b> D. STREET ADDRESS (If rural, give location) <b>1811 East Chase Street</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>6/14/03</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Na</b>		11. BIRTHPLACE (State or foreign country) <b>Na</b>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>john miller</b>		
14. MOTHER'S MAIDEN NAME <b>jennie Stokes</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Rosevelt Stokes</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary Edema</b> <b>? Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>66</b> to <b>—</b> 19 <b>—</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <b>(I) (We) (did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>R. Rampton</b>				23B. DATE SIGNED <b>11/29/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. Rampton</b>				23D. ADDRESS M.D. <b>JHH</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec 3/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. County Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>			
25B. NAME OF REGISTRAR <b>Dr. E. J. ...</b>		25C. FUNERAL DIRECTOR <b>John F. ...</b>			
25D. ADDRESS <b>11297 Caroline St</b>					

Mr. [illegible]  
[illegible]

Mr. [illegible]  
[illegible]

Trans. [illegible] Mr. [illegible]  
[illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

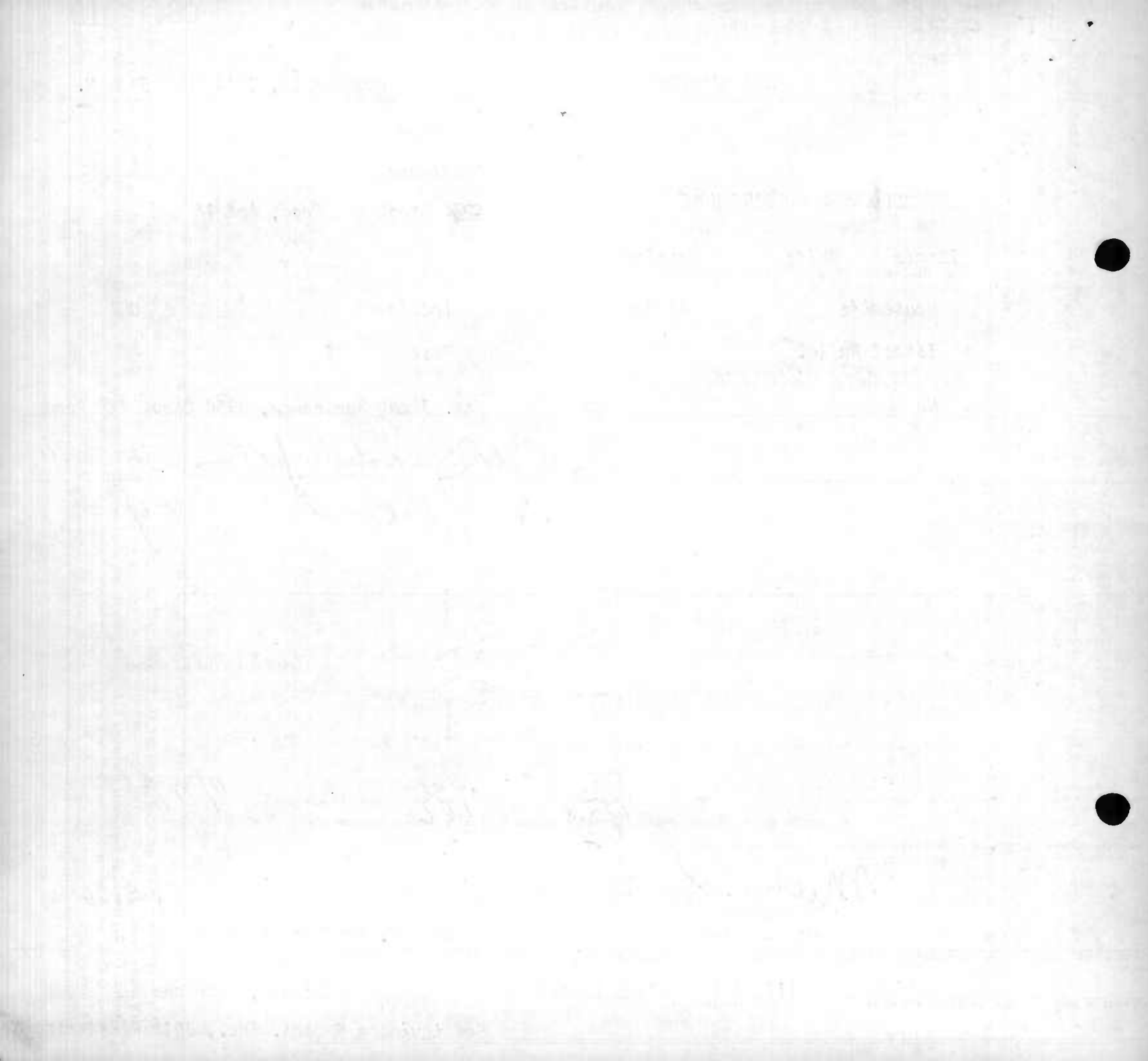
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12018</span>	
<b>66 12018</b> <b>ROSE KUSHNER</b> <b>1. NAME OF DECEASED</b> (Type or Print)			<b>2. DATE AND HOUR OF DEATH</b> November 29, 1966   10:10 A. M.		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 BELVEDERE NURSING HOME			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: Balts. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 2721 Smith Avenue		
<b>5. SEX</b> Female	<b>6. RACE</b> White	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) Married	<b>8. DATE OF BIRTH</b> May 17, 1913	<b>9. AGE</b> (In years last birthday) 53	<b>If Under 1 Yr.</b> Months: Days: Hours: Min. <b>If Under 24 Hrs.</b> Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> At Home		<b>11. BIRTHPLACE</b> (State or foreign country) New York City	
<b>13. FATHER'S NAME</b> Louis Razelsky			<b>14. MOTHER'S MAIDEN NAME</b> Becky ?		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> No		<b>17. INFORMANT</b> Mr. Bennie Kushner, 2721 Smith Avenue #9	
<b>18. I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>			<b>CAUSE OF DEATH</b> (A) <u>Metastatic carcinoma -</u> DUE TO (B) <u>Carcinoma Kidney</u> DUE TO (C) _____		
<b>INTERVAL BETWEEN ONSET AND DEATH</b> 1 yr 2 yr?					
<b>MEDICAL CERTIFICATION</b> <b>19A. DATE OF OPERATION</b> 11/29/66					
<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> no		<b>20A. AUTOPSY?</b> (Yes or No) no		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) no		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) no		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> 3/6 1966 <b>to</b> 11/29 1966 <b>that (I) (we) last saw the deceased alive on</b> 11/29 1966 <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> Maurice Feldman				<b>23B. DATE SIGNED</b> 11/29/66	
<b>23C. PHYSICIAN'S NAME</b> (Type) Maurice Feldman				<b>23D. ADDRESS</b> 2 E READ ST BALTO 2 MD	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial-Removal		<b>24B. DATE</b> 12/1/66		<b>24C. NAME of CEMETERY or CREMATORY</b> Old Montifiore	
<b>24D. LOCATION</b> (City, town, or county) (State) New York		<b>25A. DATE REC'D BY HEALTH DEPT.</b> DEC 1 1966			
<b>25B. NAME OF REGISTRAR</b> E. J. Feldman		<b>25C. FUNERAL DIRECTOR</b> Sol Levinson & Bros. Inc., 6010 Reisterstown			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12019</span>	
BIRTH NO. <span style="float: right;">66 12019</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNA HACKERMAN		November 28, 1966   5 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  90 BELVEDERE NURSING HOME		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 D. STREET ADDRESS (If rural, give location) 6930 Brookmill Road, Apt 1A			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH	9. AGE (In years lost birth day) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Latvia	
13. FATHER'S NAME Israel Raffel		14. MOTHER'S MAIDEN NAME Rose ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Jacob Hackerman, 6930 Brookmill Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 13-3-81 Acute Myocardial Infarction Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cor of Colon INTERVAL BETWEEN ONSET AND DEATH 3 months 5 yrs		CAUSE OF DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1936 to 11/28/66 that (I) (we) last saw the deceased alive on 11/28/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Milton Kirsh		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/29/66	
23C. PHYSICIAN'S NAME (Type) Milton Kirsh		23D. ADDRESS 4000 W. Northern Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/66		24C. NAME OF CEMETERY or CREMATORY Bnai Israel	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 1 1966			
25B. NAME OF REGISTRAR Sol Levinson & Bros. Inc.		25C. FUNERAL DIRECTOR ADDRESS 6010 Reisters town			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM COHEN

2. DATE AND HOUR PRONOUNCED DEAD

11-28-66

7:36 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33  
99 JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4001 Eldorado Avenue 21215

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 4, 1904

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retail

Grocer

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Morris Cohen

14. MOTHER'S MAIDEN NAME

Sarah Goldman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Mrs. Fannie Cohen, 4001 Eldorado Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-29-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/30/66

23C. NAME of CEMETERY or CREMATORY

Mikro Kodesh Beth Israel

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

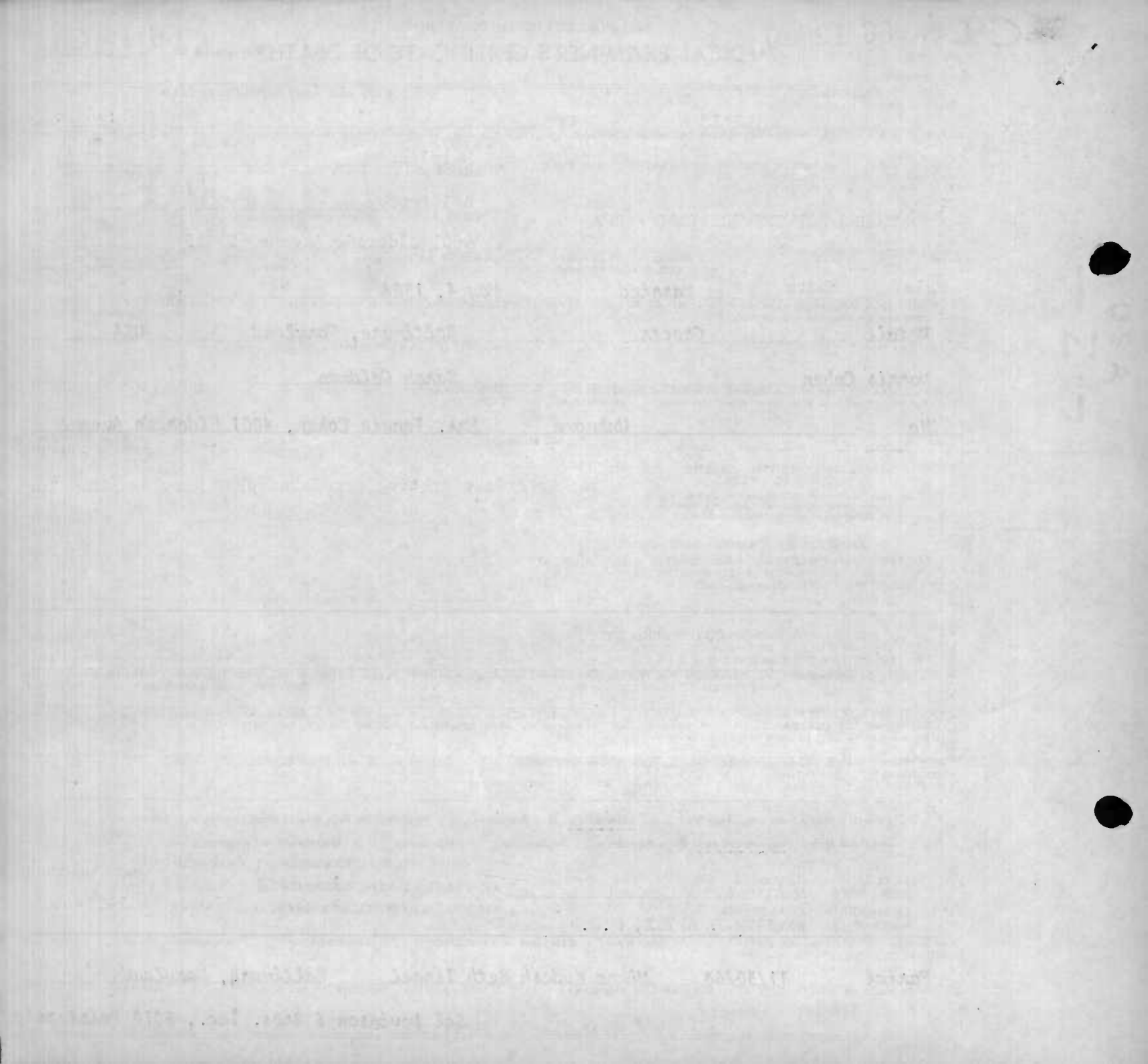
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 1 1966

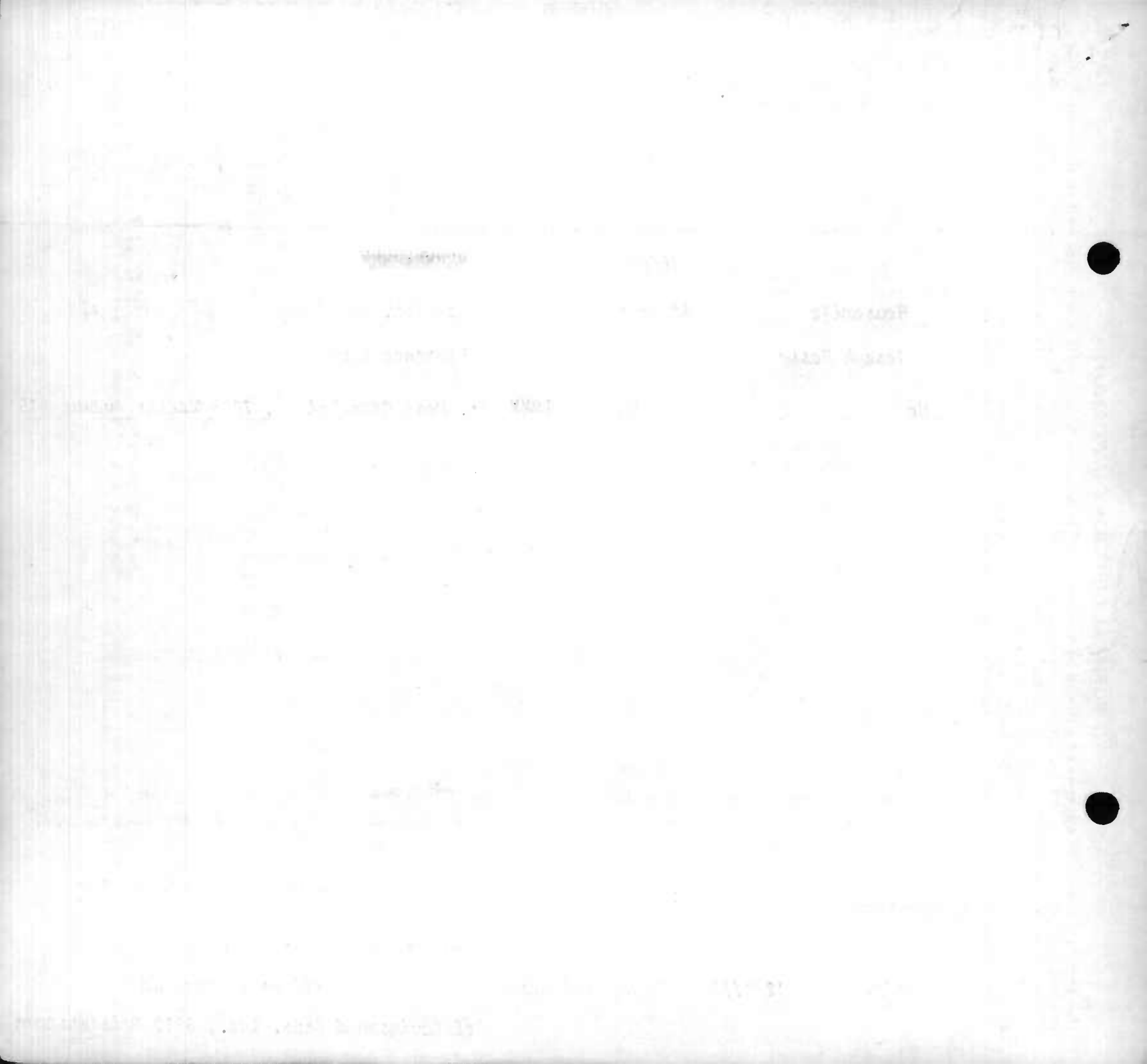
Sgl Levinson &amp; Bros. Inc., 6010 Reisterstown



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12021</u>	
BIRTH NO. <u>66 12021</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>CLARA B. HAMBURGER</u>		2. DATE AND HOUR OF DEATH <u>11.29.66</u> <u>5:15 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u> <u>42</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>27-20</u>			
		D. STREET ADDRESS (If rural, give location) <u>4000 Fallstaff Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>11/25/1901</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York, New York</u>	
13. FATHER'S NAME <u>Joseph Bassy</u>		14. MOTHER'S MAIDEN NAME <u>Florence Levy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mr. Mose Ottenheimer, 7005 Wallis Avenue #15</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>153.01</u>		CAUSE OF DEATH (A) DUE TO <u>Carcinoma of the Cecum</u> (B) DUE TO <u>Heart Failure</u> (C) <u></u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>11.25.66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cancer of the ascending colon</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11.25.66</u> 19 <u>66</u> to <u>11.29</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11.29</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Theodore</u>				23B. DATE SIGNED <u>11.29.66</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROGER THEODORE</u>		23D. ADDRESS <u>SINAI Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/2/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>SOB Levinson &amp; Bros. Inc., 6010 Reisterstown</u>	
25D. ADDRESS					



47-79-22  
NW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 66 12022

BIRTH NO. 66 12022

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Anna D. Goodman

2. DATE AND HOUR OF DEATH 28 Nov 1966 8:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland  
B. COUNTY Baltimore  
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore  
D. STREET ADDRESS (If rural, give location) 4018 Dorchester Rd. 21207

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 Eastern Avenue  
31 Baltimore City Hospitals

5. SEX Female

6. RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single

8. DATE OF BIRTH 12-6-88

9. AGE (In years last birthday) 77

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Isaac Goodman

14. MOTHER'S MAIDEN NAME Fannie Lazarus

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. 220-38-9711 A

17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave. Balto. Md. 21224

18. 433.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (CVA) (A) Middle Cerebral Occlusion (B) Atrial Fibrillation (C) Aspiration Pneumonia INTERVAL BETWEEN ONSET AND DEATH 5 mo ? 5 mo + 3 days

19. DATE OF OPERATION 198. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work Not While At Work 21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 36 SEPTEMBER 1966 to 28 Nov 1966, that (H) (we) last saw the deceased alive on 28 Nov 1966 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE Dudley A. Raine, Jr. M.D. Attending Phys. Med. Director Staff Phys. 23B. DATE SIGNED 28 Nov 1966

23C. PHYSICIAN'S NAME (Type) DUDLEY A. RAINE, JR. M.D. 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 11/30/66 24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship 24D. LOCATION Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS DEC 1 1966 Sol Levinson & Bros. Inc., 6010 Reisterstown

VS 150-REV. 1/1/65

Home D. Goodman

Baltimore City Hospitals  
F. W.

Isaac Goodman

19-6-88  
Hendy Road  
Fannie Lazarus  
4018 Dumbarton Rd  
Baltimore  
Maryland

28 Nov 1988

① Middle Central Section (CWA)

Aspiration pneumonia  
After Fluoridation  
2 2 1988

Drilling A. R. Ruff

28 Nov

1988

28 Nov 1988

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 12023				
BIRTH NO. 66 12023		M.E. CASE NO. Rose			2. DATE AND HOUR OF DEATH 11/28/66 6:45 A.M.				
1. NAME OF DECEASED (Type or Print) Anne Rosenberg					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 8211 Anita Rd				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore					5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH 8/4/09 9. AGE (In years last birthday) 57 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY At Home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Abraham Orenstein					14. MOTHER'S MAIDEN NAME Fannie Setner				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. Unknown				
17. INFORMANT Mr. Harry Rosenberg, 8211 Anita Road #8					ADDRESS				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					(A) Pulmonary Edema 5 days				
ANTECEDENT CAUSES					(B) Congestive Heart Failure 3 months				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) Arteriosclerotic Heart Disease 13 yrs. Diabetes Mellitus				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 11/22 1966 to 11/28 1966, that (we) last saw the deceased alive on 11/28 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.									
23A. SIGNATURE Allan S. Rudolph M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 11/28/66				
23C. PHYSICIAN'S NAME (Type) Allan S. Rudolph M.D.					23D. ADDRESS Sinai Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/66		24C. NAME OF CEMETERY or CREMATORY Rodde Zedek Cong.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1966			25B. NAME OF REGISTRAR Sol Levinson & Bros. Inc.			25C. FUNERAL DIRECTOR ADDRESS 6010 Reisterstown			

Sign of the cross

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen

in the name of the Father, Son and Holy Spirit

amen



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">66 12024</span>	
BIRTH NO. <span style="font-size: 1.5em;">66 12024</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Bernard Carol Swiss</span>			11/29/66 <span style="float: right;">M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE <span style="font-size: 1.1em;">Maryland</span>		
<span style="font-size: 1.5em;">90</span> Long Green Nursing Home			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.1em;">Baltimore</span>		
			D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.1em;">1018 E. Lake Ave.</span>		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
<span style="font-size: 1.1em;">Male</span>	<span style="font-size: 1.1em;">White</span>	<span style="font-size: 1.1em;">Married</span>	<span style="font-size: 1.1em;">Nov. 2, 1906</span>	<span style="font-size: 1.1em;">60</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<span style="font-size: 1.1em;">Executive</span>		<span style="font-size: 1.1em;">Accounting</span>		<span style="font-size: 1.1em;">Baltimore, Maryland</span>	
13. FATHER'S NAME <span style="font-size: 1.1em;">Joseph P. Swiss</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">ROSALIA (Not Known)</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
<span style="font-size: 1.1em;">No</span>					<span style="font-size: 1.1em;">Mrs. Ethel Swiss 1018 E. Lake Ave.</span>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">420.1 I</span>			CAUSE OF DEATH <span style="font-size: 1.2em;">Massive Myocardial Infarct 2 mos.</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <span style="font-size: 1.2em;">ASCVD</span>		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<span style="font-size: 1.1em;">0</span>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">Sept 29</span> 19 <span style="font-size: 1.1em;">Nov 29</span> 19 <span style="font-size: 1.1em;">66</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">Nov 28</span> 19 <span style="font-size: 1.1em;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Charles C. MacMinn M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">11/30/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Charles C. MacMinn, M.D.</span>				23D. ADDRESS <span style="font-size: 1.1em;">2900 E. Baltimore Street</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<span style="font-size: 1.1em;">Cremation</span>		<span style="font-size: 1.1em;">12-1-66</span>		<span style="font-size: 1.1em;">Greenmount Crematory</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<span style="font-size: 1.1em;">DEC 1 1966</span>		<span style="font-size: 1.1em;">Wm. Cook-Brooks</span>		<span style="font-size: 1.1em;">Towson 1050 York Road Towson, Maryland 21204</span>	



Released by Medical Examiner  
ON App. 1616

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12025	
BIRTH NO. 66 12025		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Clara P. Scherer			2. DATE AND HOUR OF DEATH 11-28-66 11:50 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital Linden Ave Baito. 1 Maryland			A. STATE B. COUNTY		
5. SEX Female			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
6. RACE Cauc.			D. STREET ADDRESS (If rural, give location) 1213 N. Calvert St.		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married			8. DATE OF BIRTH 2/6/78		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			9. AGE (in years last birthday) 88		
10B. KIND OF BUSINESS OR INDUSTRY Unknown			11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William C. Scherer		
14. MOTHER'S MAIDEN NAME Mary Gardner			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Same as #3		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			Pulmonary massive atelectasis		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Probable myocardial infarction - 2 hours		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Probable rupture of bulla		
19A. DATE OF OPERATION 3/11/18/66			20A. AUTOPSY? (Yes or No) Yes		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured (R) hip			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) approx. about 11-8-66			21E. INJURY OCCURRED While At Work Not While At Work		
22. I certify that (I) (this hospital) attended the deceased from 11-8-19-66 to 11-28-19-66, that (I) (we) last saw the deceased alive on 11/28 19 66 and that in (my) (our) opinion death occurred on the date and hour of from the causes stated above. (I) (we) (did) (did not) view the body after death.			21F. HOW DID INJURY OCCUR? Unknown		
23A. SIGNATURE Stanley L Blum			23B. DATE SIGNED 11/28/66		
23C. PHYSICIAN'S NAME (Type) STANLEY L BLUM			23D. ADDRESS Same as #3		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12-1-1966		
24C. NAME OF CEMETERY or CREMATORY Loudon Park			24D. LOCATION (City, town, or county) (State) Baltimore, Md		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
25C. FUNERAL DIRECTOR			25D. ADDRESS 1217 St Paul St Baltimore, Md		

2012

DE L'UNIVERSITE DE MONTREAL  
BIBLIOTHEQUE DE LA FACULTE DE DROIT  
100, RUE DE LA MONTAGNE  
MONTREAL, QUEBEC H3T 1J6  
CANADA

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 12026	
BIRTH NO. 66 12026		CERTIFICATE OF DEATH		Registered No. 66 12026	
1. NAME OF DECEASED (Type or Print) <b>Harry McCloskey</b>			2. DATE AND HOUR OF DEATH <b>November 28 66 2 20 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 MERCY HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 7-02</b> D. STREET ADDRESS (If rural, give location) <b>612 N. PORT ST.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 16, 1908</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AUTO INDUSTRY</b>		11. BIRTHPLACE (State or foreign country) <b>Balti. Md.</b>	
13. FATHER'S NAME <b>Wm. McCloskey</b>			14. MOTHER'S MAIDEN NAME <b>MARY FINN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-2062</b>		17. INFORMANT ADDRESS <b>Mrs. Marie E. McCloskey - 612 N. Port St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>161X I</b> <b>pneumonia &amp; Cachexia of terminal malignancy</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>at least 2 Ms</b> <b>at least 1 1/2 yrs</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>Tracheotomy April '65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Increasing respiratory difficulty</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>Sept. 17 1966</b> to <b>Nov. 28 1966</b> , that (H) (we) last saw the deceased alive on <b>Nov. 28 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Yinglang Lin</b> M.D.				23B. DATE SIGNED <b>Nov. 28. 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Yinglang Lin</b>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-2-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. CARMEL CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Anthony Miller - Montford &amp; Jefferson St.</b>	

THE  
GARDEN  
1811

1811

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1811

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE

DALEY

2. DATE AND HOUR PRONOUNCED DEAD

November 27, 1966

10:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 1301 Harlan Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1301 Harlan Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

6/10/11

9. AGE (In years  
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Gloucester Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Willie B Boothe

14. MOTHER'S MAIDEN NAME

Cordelia Boothe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.  
212-22-2588

17. INFORMANT

ADDRESS

Mr Louis Boothe 431 Lincoln Rd N Y, N Y

18.

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic Cardiovascular  
disease(A) \_\_\_\_\_  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ + Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 28, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/5/66

23C. NAME OF CEMETERY or CREMATORY

Bethel Baptist Cemetery

23D. LOCATION

(City, town, or county)

Gloucester Va.

24A. DATE REC'D BY HEALTH DEPT.

DEC 1 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave,

ADDRESS

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L-200

66 12028

BALTIMORE CITY HEALTH DEPARTMENT

66 12028

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

James Lewis

2. DATE AND HOUR PRONOUNCED DEAD

11/25/66 1:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

39

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

621 Mosher St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11/30/18

9. AGE (In years  
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lisbon Portugal

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Neal Lewis

14. MOTHER'S MAIDEN NAME

Sadonia Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

?

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Darlene Lewis 621 W Mosher St

18.

491X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Lobar and broncho-pneumonia, right  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty alteration of liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

partial

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/26/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/2/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Centry

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 1 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

11/30/78

11/30/78

Libertyville, Ill.

Libertyville, Ill.

John J. Smith

John J. Smith

Mrs. Barbara Smith

LIBERTYVILLE  
ILLINOIS

11/30/78 "Mr. Colvin" 11/30/78

Admission Ticket 1206

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12029

BIRTH NO. 66 12029

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LONNIE

LESENE

LESEANE

Jr.

2. DATE AND HOUR PRONOUNCED DEAD

11-28-66

7:45 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CERTIFICATE AMENDED

LUTHERAN HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2417 Lauretta Avenue 21223

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Student

8. DATE OF BIRTH

9-23-1950

9. AGE (In years  
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Student

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lonnie Lesesane

14. MOTHER'S MAIDEN NAME

Theola Gamble

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

Mrs. Theola Lesesane

ADDRESS

5417 Lauretta

18.

E 983X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Craniocerebral injury  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

School

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

3rd floor of Douglas High School

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11 28 '66 PM

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

X

21F. HOW DID INJURY OCCUR?

Struck during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-29-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-2-66

23C. NAME of CEMETERY or CREMATORY

Grubbs Mem. Pl.

23D. LOCATION

Grubbs

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 1 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Marion D. H. H.

ADDRESS

1701 Laurens St.

12/20/66 - Birth certificate for Lonnie Lesesane, Jr. Born: 8/23/50. Cert. #50-18131

*A. J. Carter*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12030				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12030	
M.E. CASE NO.				1. NAME OF DECEASED			
1. NAME OF DECEASED (Type or Print) <b>BROTHERS, ANDREW</b>				2. DATE AND HOUR OF DEATH <b>11/29/66 10 45 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
<b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL 2-9-67</b> <b>38</b>				A. STATE <b>BALTIMORE</b> B. COUNTY <b>MARYLAND</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>15-06 2906 WALBROOK AVE</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10/23/03</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemp.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Allied Chemical</b>		11. BIRTHPLACE (State or foreign country) <b>VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JESSIE</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1921-1925</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>DAUGHTER</b>	
18. <b>180X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>CAO F Lung Kidney</b> DUE TO (B) <b>WIDE SPREAD METASTASIS</b> DUE TO (C) <b>UREMIA &amp; LIVER FAILURE</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/28 1966</b> to <b>11/29 1966</b> , that (I) (we) last saw the deceased alive on <b>11/22 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joseph J. Howard</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/29</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-5-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. NAT'L</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>MORRIS J. DYETT</b>		ADDRESS <b>1701 LAURENS</b>	

Letter from University Hospital  
2-9-67 M.H.

66 12031

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12031

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN J. KIESLING

2. DATE AND HOUR PRONOUNCED DEAD

November 29, 1966 6:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

5 N. Exeter Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2240 Cambridge Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Feb. 21, 1912

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Longshore Man

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Julius Kiesling

14. MOTHER'S MAIDEN NAME

Mary Kresmant

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

3-31-42 1-19-46

16. SOCIAL  
SECURITY NO.

212-09-4954

17. INFORMANT

Louis Kiesling 2240 Cambridge Street

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Chronic Pneumonitis.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/30/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-3-1966

23C. NAME of CEMETERY or CREMATORY

Schwartz

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 1 1966

Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.

WASH. D. C. 20540

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John

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12032				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12032	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Dorothy P. Withers</b>				2. DATE AND HOUR OF DEATH <b>November 28, 1966</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>39 Provident Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1644 Bruce Ct.</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Nov. 10, 1925</b>	9. AGE (In years last birthday) <b>41</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John W. Ingram</b>			14. MOTHER'S MAIDEN NAME <b>Arria Frazier</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>129-22-6723</b>			17. INFORMANT ADDRESS <b>Mrs. Dorothy Scott 1945 W. North Avenue</b>				
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <b>Myocardial Infarction</b> (B) DUE TO <b>2nd degree</b> (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <b>11/28/66</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/28/66</b> to <b>11/28/66</b> that (I) (we) last saw the deceased alive on <b>11/28/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>W. Garner</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/29/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. GARNER M.D.</b>				23D. ADDRESS <b>1005 W Lafayette Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-1-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Ch. Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>DEC 1 1966</b>		25C. FUNERAL DIRECTOR <b>Argentine S. Phillips</b>		ADDRESS <b>1727 N. Monroe Street</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 100 66 12033		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12033	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 66 12033	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Nicholas John Raab		29 Nov 1966		12 50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY Balt. Co.	
Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		53-00 5 Choptank Avenue	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-23-01	9. AGE (In years lost in day) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Raab		14. MOTHER'S MAIDEN NAME Catherine Rebel		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-4517		17. INFORMANT BCH: Records 4940 Eastern Ave. # 21224	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Respiratory Arrest Recurrent Right Pleural + Pericardial Effusion 10mo		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) Bronchogenic Ca		1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 29 Nov 1966 to 29 Nov 1966.		that (I) (we) last saw the deceased alive on 29 Nov 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Dudley A Raine Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 29 Nov 1966	
23C. PHYSICIAN'S NAME (Type) Dudley A Raine Jr.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/2/66		24C. NAME OF CEMETERY or CREMATOR Baltimore Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR O. H. Stevens Funeral Home, Inc. 1501 E. Fort Ave	

Providence Co  
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3d Nov

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 12034					CERTIFICATE OF DEATH					Registered No. 66 12034									
M.E. CASE NO.																			
1. NAME OF DECEASED (Type and print) <b>MATTIE J. NIXON</b>					2. DATE AND HOUR OF DEATH <b>11/28/66</b> <b>5 50</b> M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY														
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIV HOSP</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 18-01</b>														
					D. STREET ADDRESS (If rural, give location) <b>806 W Lexington ST APT. 7</b>														
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED, NEVER MARRIED <b>WIDOWED</b> DIVORCED (specify)		8. DATE OF BIRTH <b>7/31/1902</b>		9. AGE (In years last birthday) <b>64</b>		If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>							
13. FATHER'S NAME <b>Thomas McClement</b>					14. MOTHER'S MAIDEN NAME <b>minie</b>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hattie Williams 2200 Booth St</b>					ADDRESS							
18. <b>260 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>diabetes mellitus</b> <b>myocardial infarct</b> <b>susp.</b>										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>adrenal apoplexy</b>																			
19A. DATE OF OPERATION <b>2</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY (Yes or No) <b>No</b>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <b>11/25</b> 19 <b>66</b> to <b>11/28</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/28</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <b>Doris E. Collier</b>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>11/28/66</b>				
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>12/3/66</b>					24C. NAME of CEMETERY or CREMATORY <b>Carver Memorial Park Laurel Md.</b>					24D. LOCATION (City, town, or county) (State) <b>Laurel Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>					25B. NAME OF REGISTRAR <b>A. E. E. E.</b>					25C. FUNERAL DIRECTOR <b>Charles A. Rice 6610 Barre St</b>					ADDRESS				



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12035</b>	
BIRTH NO. <b>66 12035</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Ella Margarette Madda Ford</b>		2. DATE AND HOUR OF DEATH <b>12/1/66 3:10 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 27-12</b> D. STREET ADDRESS (If rural, give location) <b>406 Gittings Avenue</b>	
5. SEX <b>F</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>01/18/02</b>
9. AGE <b>64</b> years (lost birthday)		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEC-Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BOOK STORES</b>	
11. BIRTHPLACE (State or foreign country) <b>TORONTO CANADA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herbert Stephenson</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Smith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-24-1509</b>	
17. INFORMANT <b>Mrs. Walter Baggs - Same</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteinemia, etc. It means the disease, injury or complication which caused death.) <b>Cirrhosis of the Liver 2 years</b> <b>Hypostatic bronchopneumonia</b> <b>Hepatic Coma</b> <b>Neutritional Cirrhosis</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>Interval between ONSET AND DEATH</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>11/25/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gastro Intestinal Bleeding</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/24/66</b> to <b>12/1/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert P. Doyle</b> M.D.		23B. DATE SIGNED <b>12/1/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT P. DOYLE</b> M.D.		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>12/3/1966</b>	
24C. NAME of CEMETERY or CREMATORY <b>Greenmount</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>		25B. NAME OF REGISTRAR <b>H.W. Jenkins &amp; Sons Co.</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>			

10/1/00

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10/1/00

Robert P. Doyle  
Robert P. Doyle



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 12036					CERTIFICATE OF DEATH					Registered No. 66 12036				
1. NAME OF DECEASED (Type or Print) <b>FLORENCE A. RUSK</b>										2. DATE AND HOUR OF DEATH <b>11/28/66 800 PM.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>27-11 425 WINSTON AVE.</b>				
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>8/20/85</b>		9. AGE (In years last birthday) <b>81</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not Known</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		
13. FATHER'S NAME <b>Joseph W. HATH</b>					14. MOTHER'S MAIDEN NAME <b>ANNIE Dobbins</b>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>218-10-54030</b>		17. INFORMANT <b>Patient Chart</b>			ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b>										INTERVAL BETWEEN ONSET AND DEATH <b>36 hr?</b>				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (M) (this hospital) attended the deceased from <b>11/27 1966</b> to <b>11/28 1966</b> , that (M) (we) last saw the deceased alive on <b>11/28 1966</b> and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above. (M) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>John R. Vaughn Jr.</b>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/28/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>JOHN RICHARD VAUGHN, JR</b>										23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL CALVERT &amp; 33RD STREETS, BALTIMORE, MD</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>12/2/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1966</b>					25B. NAME OF REGISTRAR <b>H. D. Jenkins</b>					25C. FUNERAL DIRECTOR <b>H. D. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>				

Exhibit 11-1750

Union Memorial Hospital

Female White Wounded

Not known  
Joseph Wyatt  
No

Unknown Patient Chest

452 Winston Ave  
Baltimore  
Maryland Baltimore

8/20/82 81

Maryland  
Anne Tobbin

Central Vaccine Accident 21

No

J. M. W. J.

U. S. A. C. J.

11/55

11/55

11/55

x

THE U. S. A. C. J. ALIEN

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 12037					CERTIFICATE OF DEATH		Registered No. 66 12037			
1. NAME OF DECEASED (Type or Print) <i>HIRSCH, William, Edward</i>					2. DATE AND HOUR OF DEATH <i>29 Nov 1966 16:20 P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Ind. Hospital</i>					A. STATE <i>Md.</i>					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto 21-02</i>					
					D. STREET ADDRESS (If rural, give location) <i>1113 W. Hamburg St.</i>					
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>Divorced</i>	8. DATE OF BIRTH <i>26 Sept 1894</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. filling station operator</i>			11. BIRTHPLACE (State or foreign country) <i>Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
13. FATHER'S NAME <i>John Adam Hirsch</i>			14. MOTHER'S MAIDEN NAME <i>Agnes Brown</i>			17. INFORMANT ADDRESS <i>Same as above</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>212-09-3841</i>							
18. <i>420.1 I</i>					CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO <i>Acute Massive Myocardial infarction</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO					
					(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<i>Acute arterial occlusion (R) femoral</i>					
19A. DATE OF OPERATION <i>25 Nov 1966</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>SEE ABOVE</i>			20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>20 Nov 1966</i> to <i>29 Nov 1966</i> , that (I) (we) last saw the deceased alive on <i>29 Nov 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Delfin S. Santos</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>29 Nov 1966</i>			
23C. PHYSICIAN'S NAME (Type) <i>Delfin S. Santos</i>					23D. ADDRESS <i>University of Maryland Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>12/3/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Catholic Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Ind.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 1 1966</i>			25B. NAME OF REGISTRAR <i>R. E. Roberts</i>			25C. FUNERAL DIRECTOR <i>John J. Brown</i>			ADDRESS <i>901 Madison St. Balto 21223</i>	



1  
G-663

66 12038

BALTIMORE CITY HEALTH DEPARTMENT

66 12038

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

NICHOLAS GIRARDIN

2. DATE AND HOUR PRONOUNCED DEAD

11-29-66 3:46 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33  
99  
JOHNS HOSPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland BALTO Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

8545 Pulaski Highway Baltimore 21221

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Sept 4, 1904

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NY

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank J. Girardin

14. MOTHER'S MAIDEN NAME

Anna Kust

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL  
SECURITY NO.

106-16-247

17. INFORMANT

Ed. Storkblinger

ADDRESS

Lockport NY

18.

443X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic and hypertensive

XXXX

cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-29-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

12/3/66

23C. NAME of CEMETERY or CREMATORY

LOCKPORT NY

23D. LOCATION

(City, town, or county)

(State)

LOCKPORT NY

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

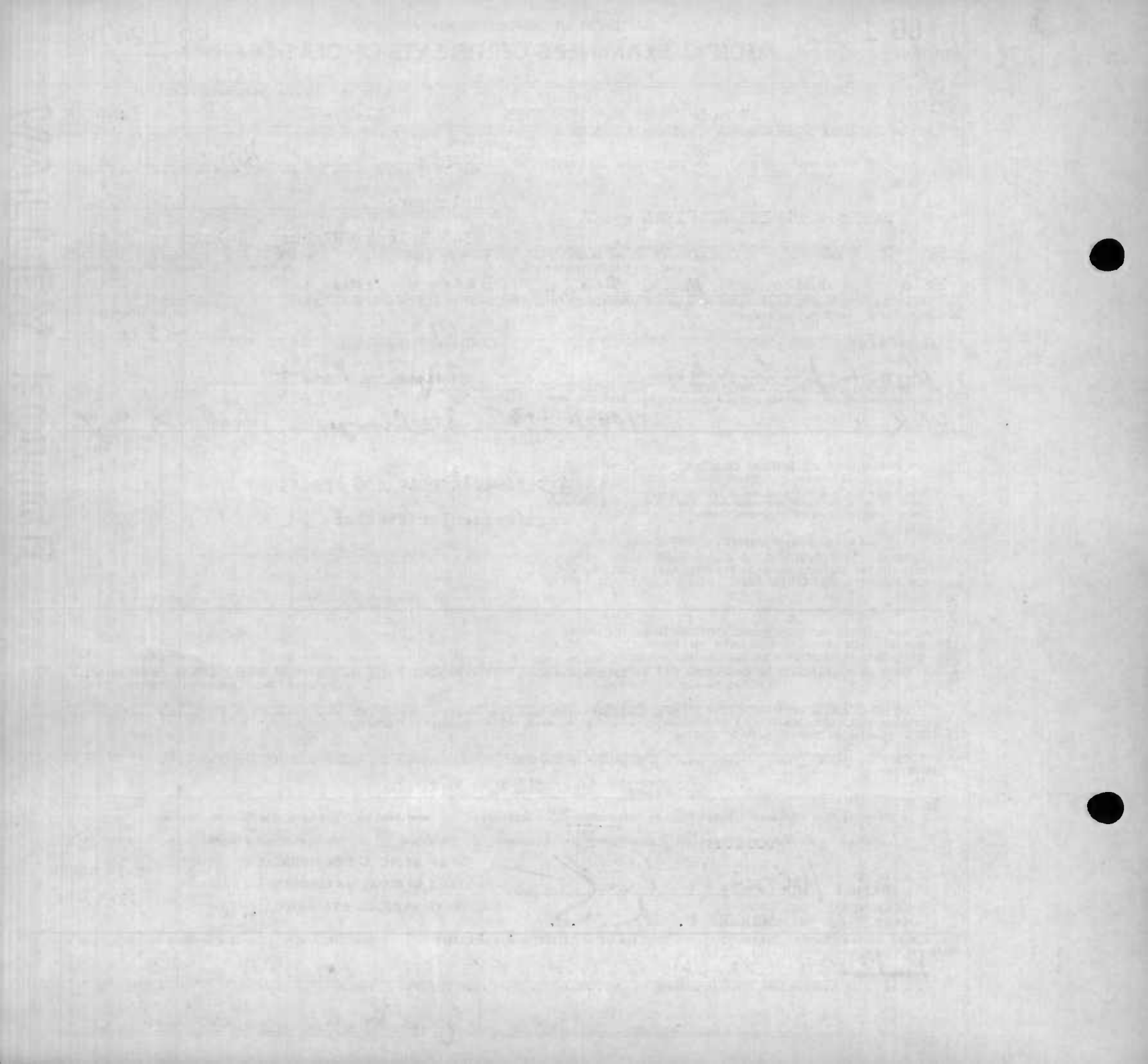
ADDRESS

DEC 2 1966

W. U. Spitz

Connelly

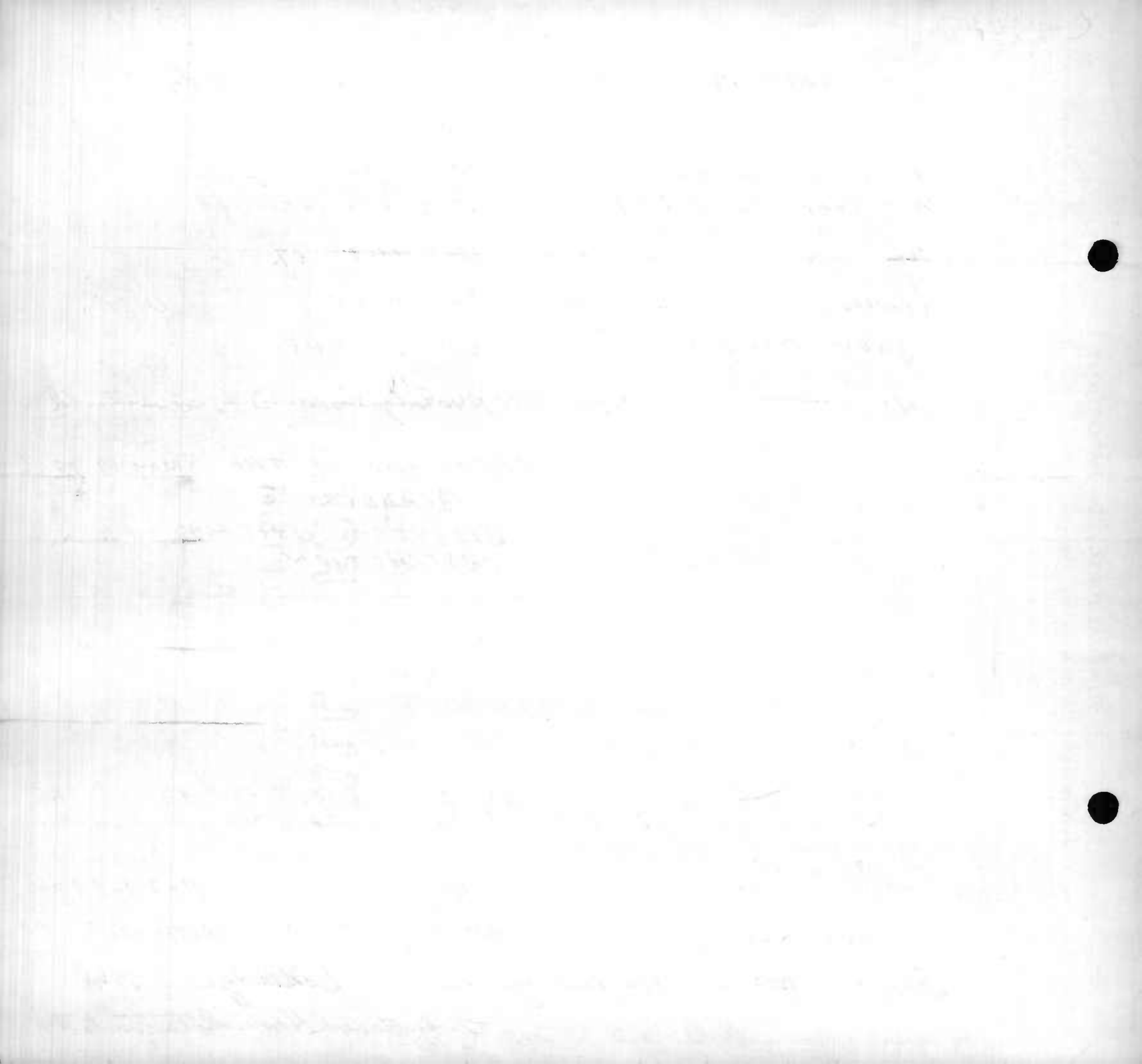
300 more



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12039				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12039	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <b>JOHN M. CONELIUS</b>				2. DATE AND HOUR OF DEATH <b>11-29-1966 8<sup>14</sup> PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4313 FLOWERTON RD. BALTIMORE, MD. 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 28-04</b> D. STREET ADDRESS (If rural, give location) <b>4313 FLOWERTON RD.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>11-11-1907</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CRAFTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TRAILER TRUCK</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN CONELIUS</b>				14. MOTHER'S MAIDEN NAME <b>WINIFERD KELLY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-5714</b>		17. INFORMANT ADDRESS <b>Mo Evelyn Conelius 4313 Flowerton Rd</b>			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA OF THE BLADDER &amp; BILATERAL URETERAL OBSTRUCTION</b>				INTERVAL BETWEEN ONSET AND DEATH <b>MAY 17, 1966</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 17, 1966</b> to <b>NOV. 29, 1966</b> , that (I) <del>we</del> last saw the deceased alive on <b>JULY 1, 1966</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Emile Kfoury</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11-29-1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>EMILE KFOURY</b>		23D. ADDRESS M.D. <b>100 N. BROADWAY BALTIMORE 31, MD.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-2-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Ind.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>		25B. NAME OF REGISTRAR <b>John E. ...</b>		25C. FUNERAL DIRECTOR <b>John E. ...</b>		ADDRESS <b>Home ...</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12040		CERTIFICATE OF DEATH				Registered No. 66 12040			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) C. Albert Baldwin					2. DATE AND HOUR OF DEATH 11/30/66 4:25 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 2504				
					D. STREET ADDRESS (If rural, give location) 3547 4th Street Balto. 25, Md.				
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 1-20- 1900		9. AGE (In years last birthday) 66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tank Maint.		10B. KIND OF BUSINESS OR INDUSTRY U. S. Ind. Chem.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Charles Baldwin					14. MOTHER'S MAIDEN NAME Anna Brecker				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 215-03-2610		17. INFORMANT ADDRESS 21225 Mrs. Marie Rudolph 3547 Fourth St. Balto.		
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from 10/14/66 to 11/30/66 that (X) (we) last saw the deceased alive on 11/30/66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Camilo C. Balacuit Jr. M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 11/30/66	
23C. PHYSICIAN'S NAME (Type) CAMILO C. BALACUIT, JR., MD.					23D. ADDRESS S.B.G.H. - 1213 Light Street				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 3, 1966		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hwy. A. A. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. (21225)			

4/27/14

11/20/14

11/20/14

11/20/14

11/20/14

66 12041

BALTIMORE CITY HEALTH DEPARTMENT

66 12041

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>MARIE L. HALLAMEYER</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>November 30, 1966 10:00 A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secour Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 20-05</b> D. STREET ADDRESS (If rural, give location) <b>2106 Eagle Street</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Nov. 1, 1939</b>	9. AGE (in years last birthday) <b>27</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HEIMILLER</b>			14. MOTHER'S MAIDEN NAME <b>Un Known</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NONE</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>Joseph Hallameyer 2106 Eagle St.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E916.9</b> <b>(A) Carbon Monoxide Intoxication.</b> DUE TO <b>(B) DUE TO</b> <b>(C) DUE TO</b> INTERVAL BETWEEN ONSET AND DEATH							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2106 Eagle Street 20-05</b>			
21D. TIME OF INJURY (APPROX.) <b>11 30 '66 A</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Conflagration</b>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Petty</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/30/66</b>							
23A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23B. DATE <b>12-2-66</b>		23C. NAME OF CEMETERY or CREMATORY <b>London Park</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>		24B. NAME OF REGISTRAR <b>R. G. E. Taylor</b>		24C. FUNERAL DIRECTOR ADDRESS <b>660 L. Schaub Funeral Home</b> <b>Marion W. Miller 2101 Frederick Ave.</b>			

WALL STREET JOURNAL  
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H-456

66 12042

BALTIMORE CITY HEALTH DEPARTMENT

66 12042

BIRTH NO. 66-05823 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

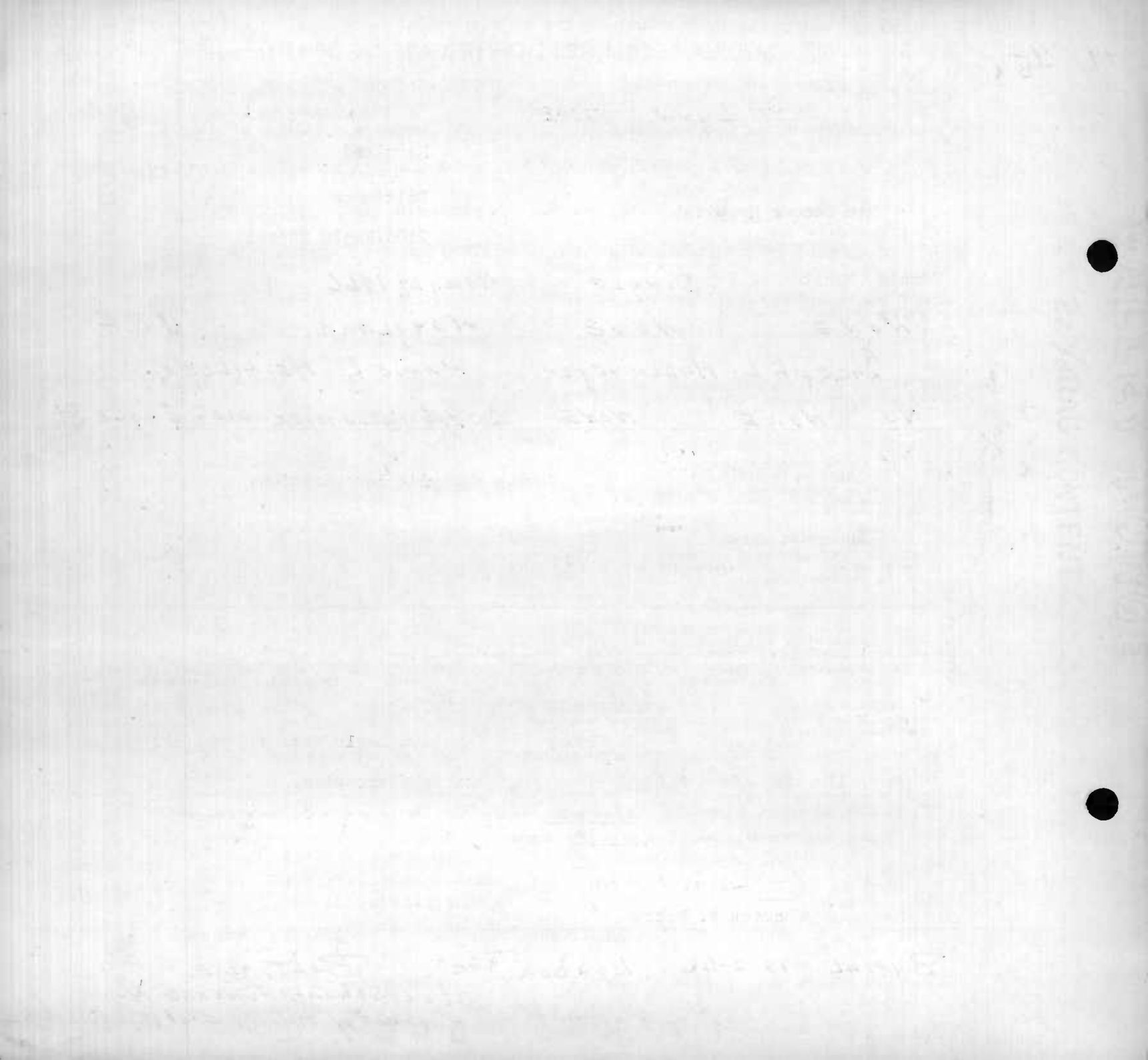
1. NAME OF DECEASED (Type or Print) <b>TAMMY Lynn HALLAMEYER</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>November 30, 1966 10:00 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>34 Bon Secour Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 20-05</b> D. STREET ADDRESS (If rural, give location) <b>2106 Eagle Street</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>MARCH 19, 1966</b>	9. AGE (In years last birthday) <b>8</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph L. Hallameyer</b>			14. MOTHER'S MARDEN NAME <b>MARIE L. HEIMILLER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT ADDRESS <b>Joseph Hallameyer 2106 Eagle St.</b>		

18. <b>E916.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>Carbon Monoxide Intoxication.</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>2106 Eagle Street 20-05</b>			
21D. TIME OF INJURY (APPROX.) <b>11 30 '66 A</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Conflagration.</b>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/30/66</b>	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			

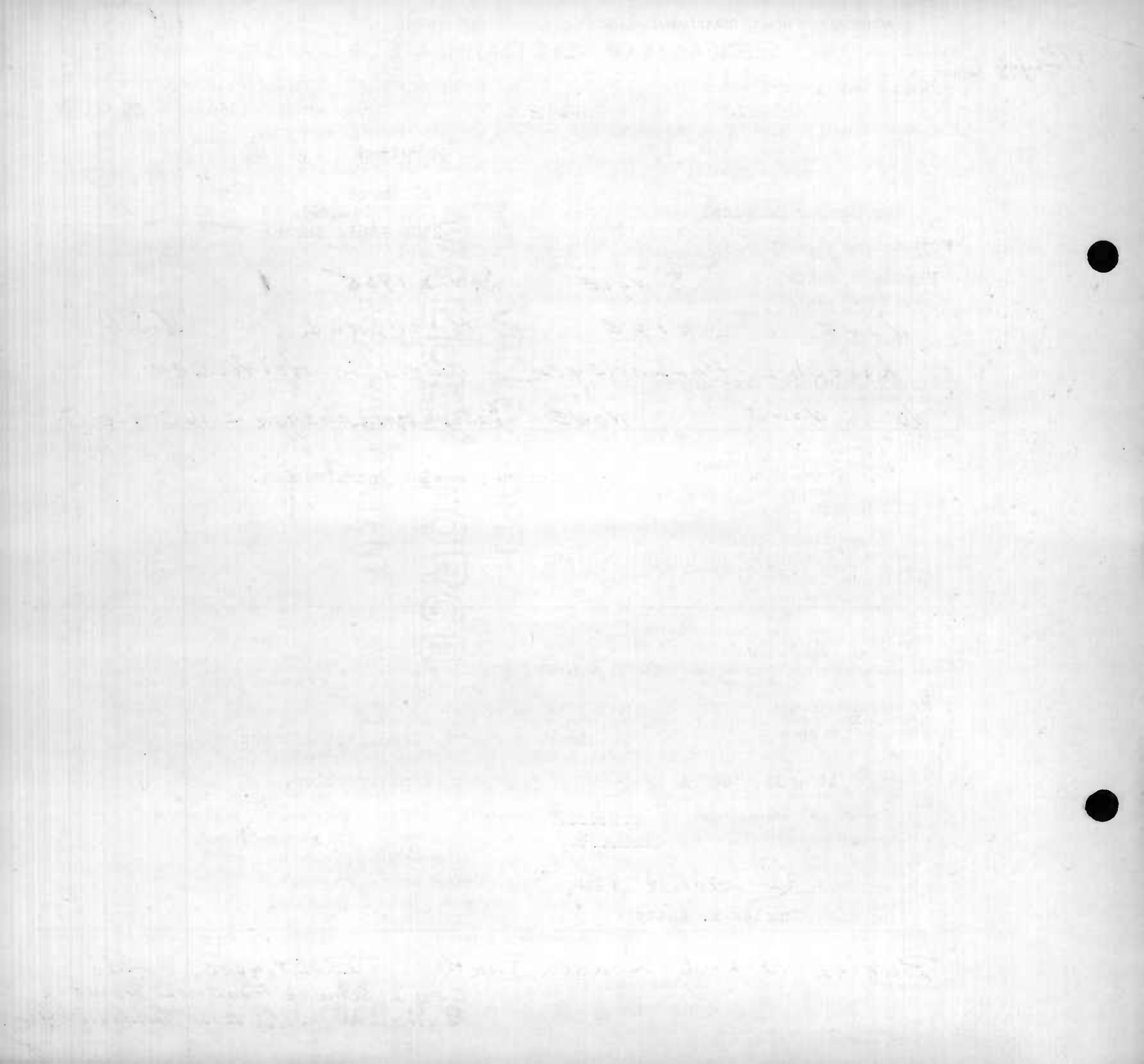
23A. BURIAL CREMATION, REMOVAL (Specify) <b>BYRIAL</b>	23B. DATE <b>12-2-66</b>	23C. NAME OF CEMETERY or CREMATORY <b>London Park</b>	23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
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24A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>	24B. NAME OF REGISTRAR <b>R. B. E. Taylor</b>	24C. FUNERAL DIRECTOR <b>Geo. L. Schwab FUNERAL HOME</b>	ADDRESS <b>2101 Frederick Ave.</b>
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66 12043		BALTIMORE CITY HEALTH DEPARTMENT		66 12043	
BIRTH NO. <u>65-00874</u> MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. _____	
M.E. CASE NO. _____					
1. NAME OF DECEASED (Type or Print) <u>MICHELLE HALLAMEYER</u>			2. DATE AND HOUR PRONOUNCED DEAD <u>November 30, 1966</u> <u>10:00</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secour Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2106 Eagle Street</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JAN. 8, 1965</u>	9. AGE (In years last birthday) <u>1</u>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Joseph L. HALLAMEYER</u>			14. MOTHER'S M.A.DEN NAME <u>MARIE L. HEINILLER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Joseph HALLAMEYER 2106 EAGLE ST.</u>	
18. CAUSE OF DEATH <u>E916.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Carbon Monoxide Intoxication.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>2106 Eagle Street</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>11 30 '66 A</u>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Conflagration.</u>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles S. Petty</u> M.D. EXAMINER'S NAME (Type) <u>Charles S. Petty</u>					
23A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23B. DATE <u>12-2-66</u>		23C. NAME OF CEMETERY or CREMATORY <u>London Park</u>	
23D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>		24A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1966</u>			
24B. NAME OF REGISTRAR <u>Charles S. Petty</u>		24C. FUNERAL DIRECTOR <u>Geo. L. Schwab FUNERAL HOME</u>			
24D. ADDRESS <u>2101 Auden Lane</u>					





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BALTIMORE CITY HEALTH DEPARTMENT  
BIRTH NO. 66 12044 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12044  
M.E. CASE NO. 62-13905

1. NAME OF DECEASED (Type or Print) TIMOTHY HALLAMEYER 2. DATE AND HOUR PRONOUNCED DEAD November 30, 1966 10:00 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
34 Bon Secour Hospital  
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland  
C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore  
D. STREET ADDRESS (If rural, give location) 2106 Eagle Street

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE 8. DATE OF BIRTH JUNE 1, 1962 9. AGE (In years last birthday) 4  
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 10B. KIND OF BUSINESS OR INDUSTRY NONE 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph L. Hallameyer 14. MOTHER'S MAIDEN NAME MARIE L. HEIMILLER  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE 16. SOCIAL SECURITY NO. NONE 17. INFORMANT ADDRESS Joseph Hallameyer 2106 Eagle St.

18. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
E9160  
Carbon Monoxide Intoxication.  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2106 Eagle Street  
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 11 30 '66 A 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? Conflagration.

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 11/30/66  
EXAMINER'S NAME (Type) Charles S. Petty ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 12-2-66 23C. NAME of CEMETERY or CREMATORY LONDON PARK 23D. LOCATION (City, town, or county) (State) BALTIMORE, MD.  
24A. DATE REC'D BY HEALTH DEPT. DEC 2 1966 24B. NAME OF REGISTRAR Charles S. Petty 24C. FUNERAL DIRECTOR ADDRESS Geo. L. Schwab Funeral Home 3101 Rudolph Ave.

REPORT OF THE

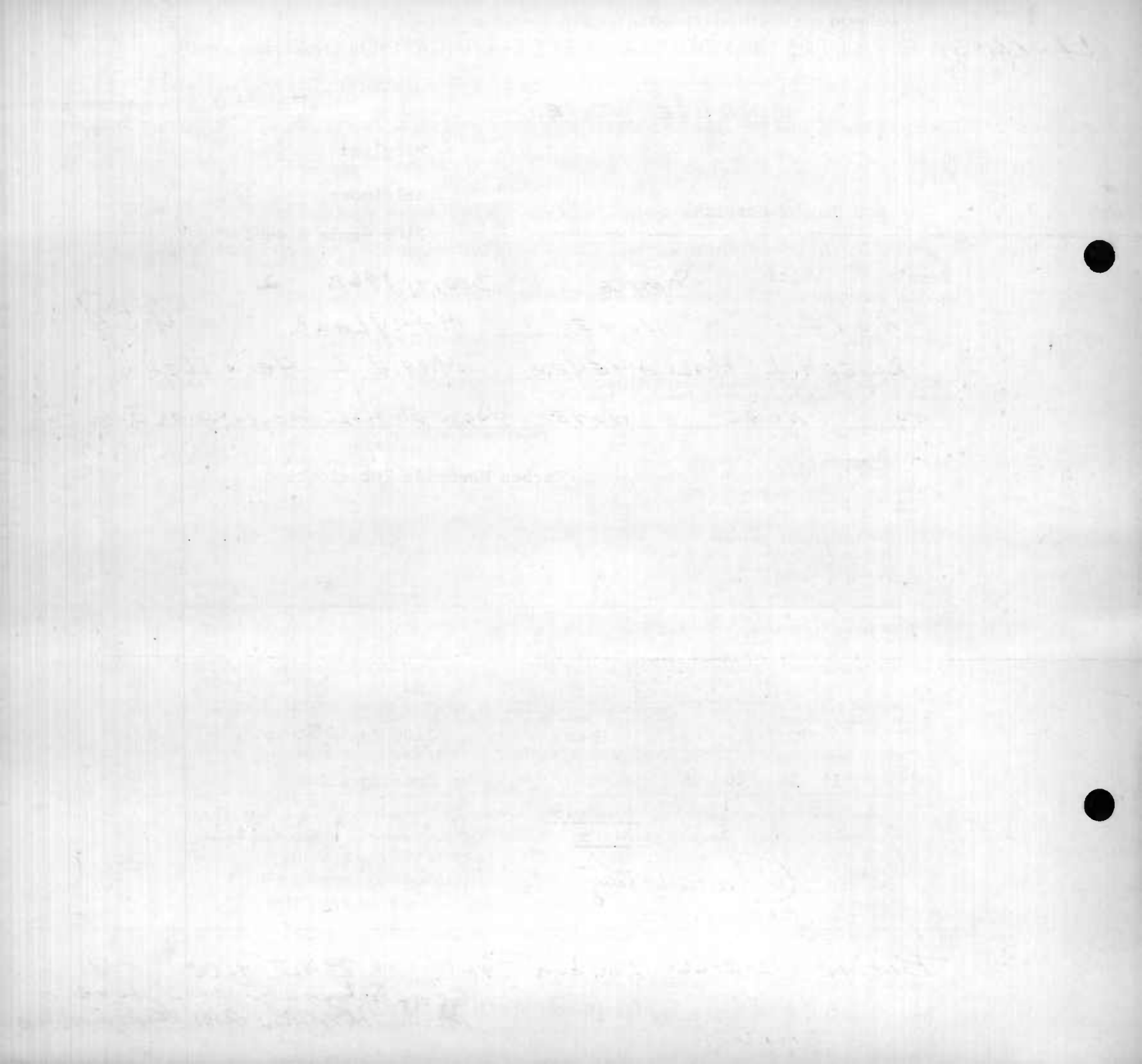
WALSH REPORT

PERIOD

66 12045  
 BIRTH NO. 63-33844  
 M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

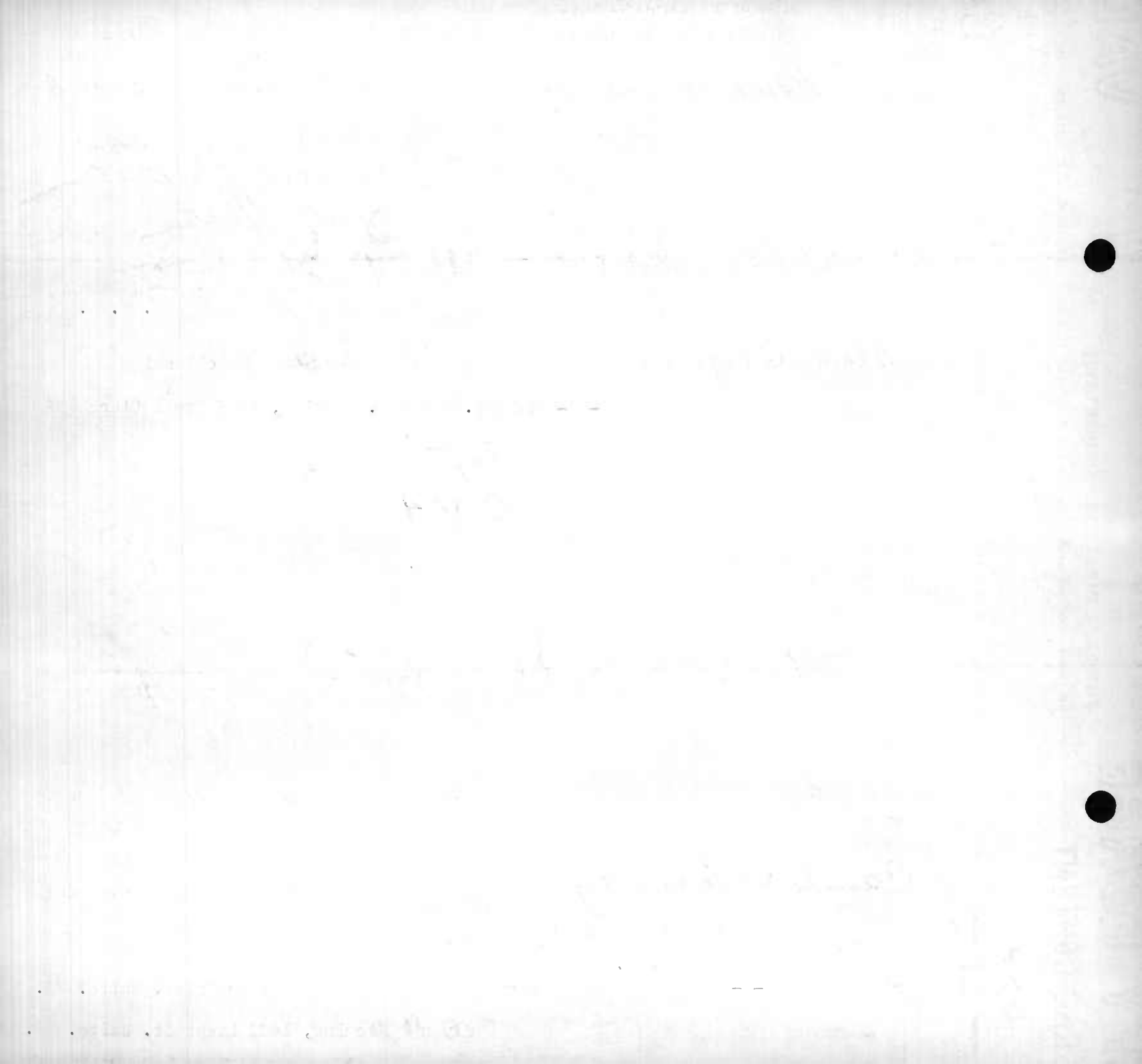
1. NAME OF DECEASED (Type or Print) <b>BRENDA LEE HALLAMEYER</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>November 30, 1966 10:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>34 Bon Secour Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 20-05</b> D. STREET ADDRESS (If rural, give location) <b>2106 Eagle Street</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>DEC 1, 1963</b>	9. AGE (In years last birthday) <b>2</b>	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph L. Hallameyer</b>				14. MOTHER'S MAIDEN NAME <b>MARIE L. Heimiller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>Joseph Hallameyer 2106 Eagle St</b>			
18. <b>E 916.01</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) <b>Carbon Monoxide Intoxication.</b> DUE TO			
				(B) _____ DUE TO			
				(C) _____			
				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2106 Eagle Street 20-05</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>11 30 '66 A</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Conflagration.</b>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Petty</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/30/66</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23B. DATE <b>12-2-66</b>		23C. NAME of CEMETERY or CREMATORY <b>London Park</b>		23D. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>		24B. NAME OF REGISTRAR <b>W. B. J. J. J.</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Geoff Schaub FUNERAL HOME 2101 Redwoodline</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 12046		<b>CERTIFICATE OF DEATH</b>		66 12046	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Helen G. Fanning</i>		2. DATE AND HOUR OF DEATH <i>11-30-66 8:00 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland.</i> B. COUNTY <i>2505</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21225</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1005 Stoll Place.</i>	
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>9-28-05</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>CLERK</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Adam Gregoski</i>		14. MOTHER'S MAIDEN NAME <i>Theodosia Kopchinski</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-05-8614</i>		17. INFORMANT ADDRESS <i>Mr. Harry W. Fanning, 1005 Stoll Place #25</i>	
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Septicemia</i> <i>CVA</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDICTION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>at</del> (this hospital) attended the deceased from <i>11-6</i> 19 <i>66</i> to <i>11-30</i> 19 <i>66</i> and that <del>at</del> (we) last saw the deceased alive on <i>11-30</i> 19 <i>66</i> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Camilo C. Balacuit, Jr.</i> M.D.				23B. DATE SIGNED <i>11-30-66.</i>	
23C. PHYSICIAN'S NAME (Type) <i>Camilo C. Balacuit, Jr.</i>		23D. ADDRESS <i>1213 Light St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-3-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <i>Flannery Fleming, 1422 Light St. Balto. Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66 12047</u>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. <u>66 12047</u>	
M.E. CASE NO.				1. NAME OF DECEASED <u>Pinto, Teresa</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 1, 1966</u>   <u>2</u> <u>55</u> <u>AM</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>Baltimore</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and, give township) <u>Baltimore</u>		28-04			
				D. STREET ADDRESS (If rural, give location) <u>401 Kingston Road</u>					
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-28-1899</u>	9. AGE (In years last birthday) <u>67 yrs.</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Swall</u>				14. MOTHER'S MAIDEN NAME <u>?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Mathew L. Pinto, Jr.</u> <u>401 Kingston Rd.</u>		ADDRESS		
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Congestive Heart Failure</u> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(B) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>years</u>					
				(C)					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>NOVEMBER 29</u> 19 <u>66</u> to <u>DECEMBER 1</u> 19 <u>66</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>DECEMBER 1</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <u>Hun Kim</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Dec. 1, 1966</u>			
23C. PHYSICIAN'S NAME (Type) <u>HUN KIM</u>				M.D.		23D. ADDRESS <u>Bon Secours Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>12-3-66 Burial</u>		24B. DATE <u>12-3-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Witzke F.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke F.D.</u>		ADDRESS <u>401 Edmondson Av.</u>			

1910, 1911

Don't know how to  
do it

1910, 1911

1910, 1911

1910, 1911

Artificial Heart Failure  
Congestive Heart Failure

Yes

NOVEMBER 1910  
DECEMBER 1910

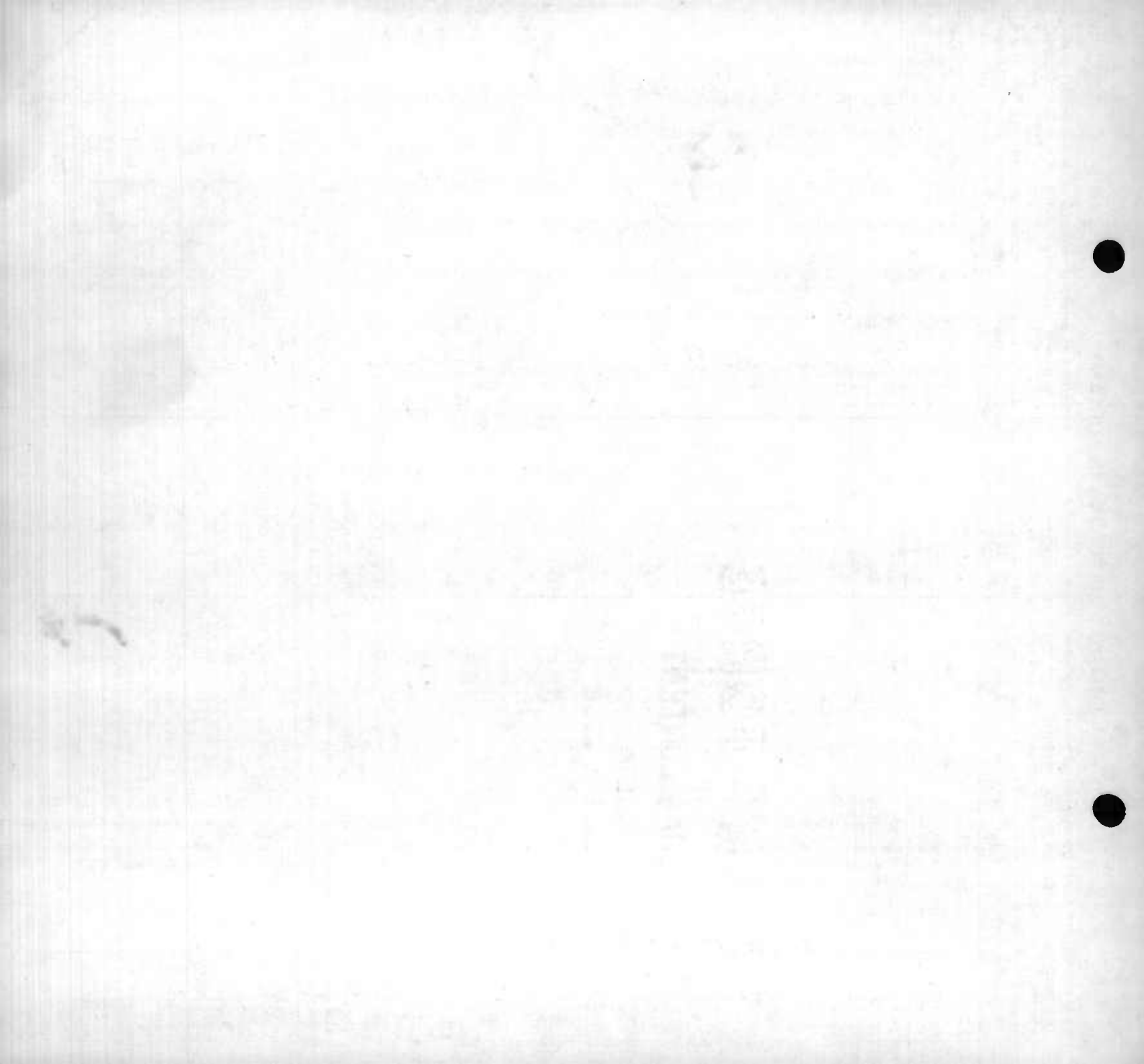
Don't know how to



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

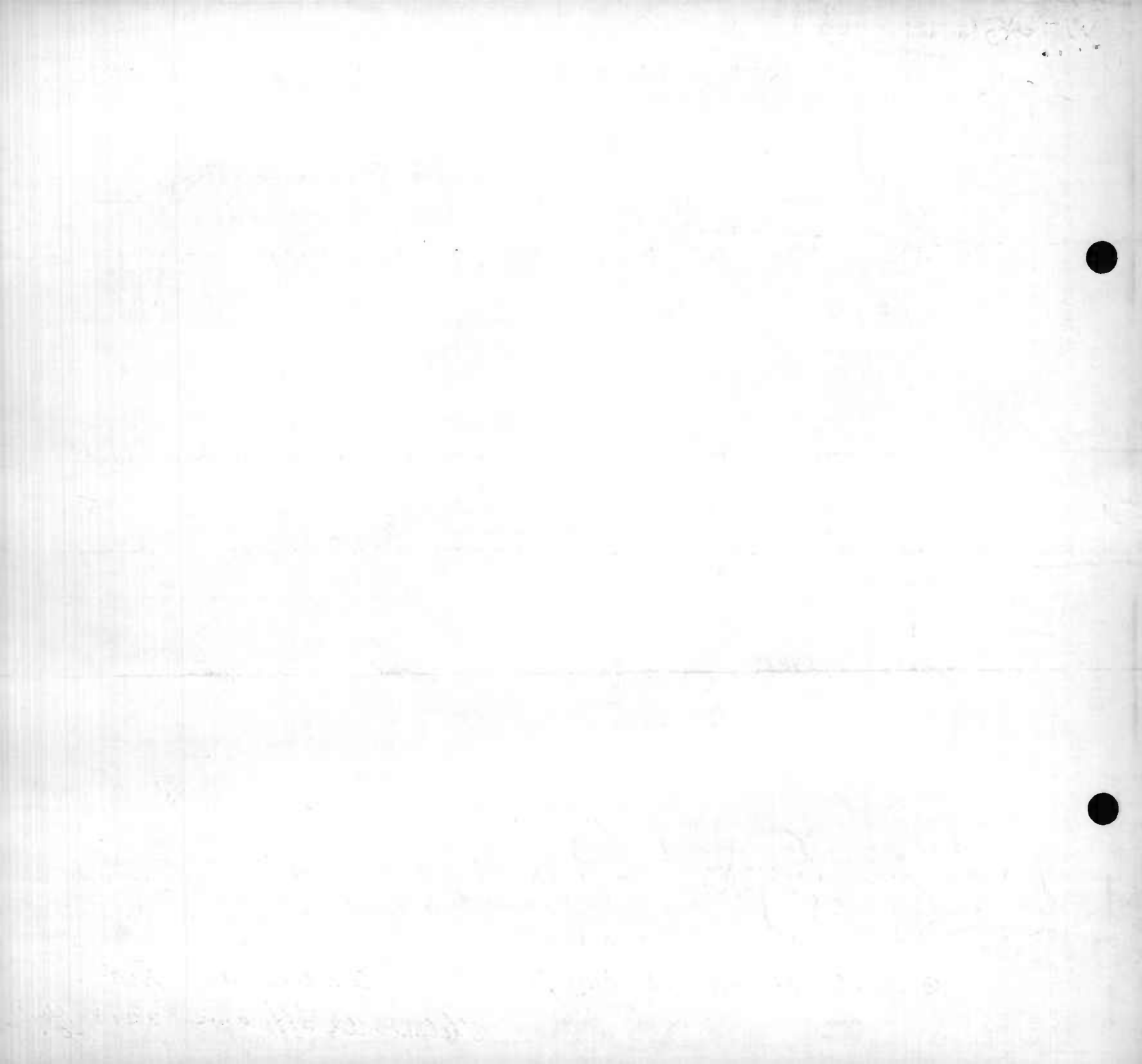
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 12048		CERTIFICATE OF DEATH		X 66 12048	
1. NAME OF DECEASED (Type or Print) John W. Slotter			2. DATE AND HOUR OF DEATH 11-26-66 10:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard Co. C. CITY OR TOWN Jessup (If outside city limits, write RURAL and give township) 63-00 D. STREET ADDRESS (If rural, give location) Rte 175		
5. SEX M	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 10-28-90	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orchid Grower		10B. KIND OF BUSINESS OR INDUSTRY Horticultural		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Francis Slotter		14. MOTHER'S MAIDEN NAME Agnes Brown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2		16. SOCIAL SECURITY NO. 220-44-7035		17. INFORMANT Hospital Chart ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Hemorrhagic Gastric Polyp OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 7.		
19A. DATE OF OPERATION 11-14-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (1) UGT Bleeding (2) DUGT Bleeding		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) No		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> No		21F. HOW DID INJURY OCCUR? No	
22. I certify that (H) (this hospital) attended the deceased from 11-3-66 to 11-26-66, that (H) (we) last saw the deceased alive on 11-26-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry A. Saronitz			23B. DATE SIGNED 11-26-66		
23C. PHYSICIAN'S NAME (Type) HENRY A. SARONITZ M.D.			23D. ADDRESS		
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11-29-66		24C. NAME OF CEMETERY OR CREMATORY Mount Airy Cemetery Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1966		25B. NAME OF REGISTRAR Charles E. Johnson		25C. FUNERAL DIRECTOR De Witt Sanderson Laurel Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 12049					66 12049				
BIRTH NO.					Registered No.				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <b>ROBERT L. WAGNER</b>				
2. DATE AND HOUR OF DEATH <b>11/26/66 10:30 P.M.</b>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hosp.</b>					A. STATE B. COUNTY				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, Md. 26-11</b>				
D. STREET ADDRESS <b>901 S. Bouldin St.</b>									
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>1-1-1914</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Canton RR</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>md.</b>		
13. FATHER'S NAME <b>Wagner - ?</b>					14. MOTHER'S MAIDEN NAME <b>STella ?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. <b>241X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Septicemic, multiple septic emboli</b>			CAUSE OF DEATH (A) DUE TO <b>proteus pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <b>status Astmaticus</b>			<b>1 wk</b>			
(C)						<b>years</b>			
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>11/26/66</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostheses</b>			20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/16/66</b> to <b>11/26/66</b> and that (I) (we) last saw the deceased alive on <b>11/26/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.									
23A. SIGNATURE <b>Narong Ruangruchira</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/27/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>NARONG RUANGRUCHIRA</b>					23D. ADDRESS <b>MERCY Hosp.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-1-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Mary's</b>			24D. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>			25B. NAME OF REGISTRAR <b>W. B. Hoffmann</b>			25C. FUNERAL DIRECTOR ADDRESS <b>3218 Hudson St.</b>			

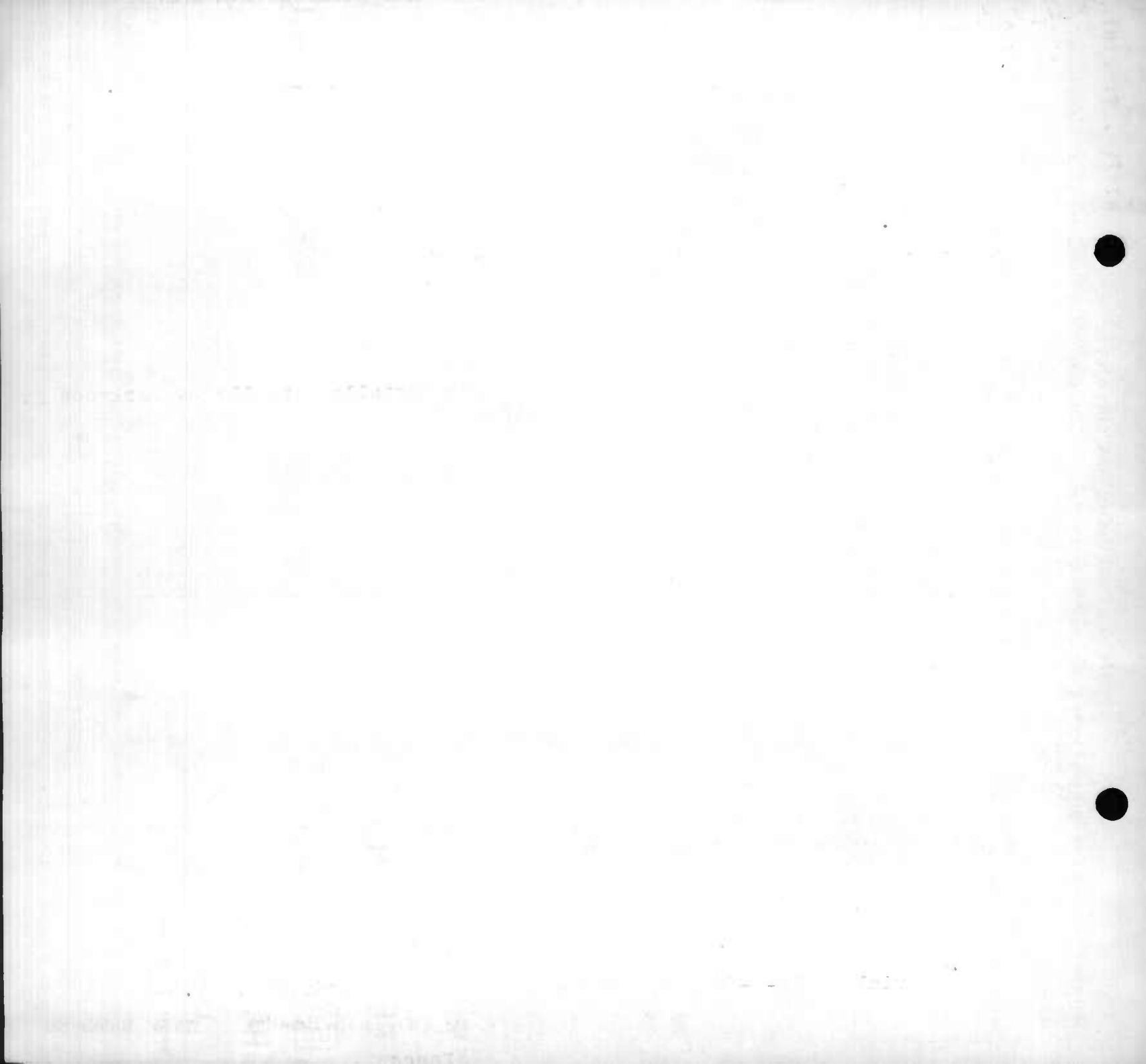


64 13 31  
MORTON, TIMOTHY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12050	
BIRTH NO. 66 12050				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>TIMOTHY MORTON</b>			2. DATE AND HOUR OF DEATH <b>11-29-66</b>   <b>11.10 P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>			D. STREET ADDRESS (If rural, give location) <b>2834 PARKWOOD AVENUE 21215</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>4-10-88</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>TIMOTHY MORTON</b>			14. MOTHER'S MAIDEN NAME <b>FRANCES</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-07-6717</b>	17. INFORMANT <b>Mrs Vertelle Ransall</b>		ADDRESS <b>12834 Parkwood Av</b>
18. <b>465X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Emboli</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> <b>1966</b> to <b>11/29</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Stan Wilson</b>				23B. DATE SIGNED <b>11/29/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. Stan Wilson</b>				23D. ADDRESS <b>J H H</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-3-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>			
24F. NAME OF REGISTRAR <b>12-3-8 J. J. J. J.</b>		24G. FUNERAL DIRECTOR <b>Mrs Frances A. Hemslor</b>		24H. ADDRESS <b>578 W. Biddle St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12051</b>	
BIRTH NO. <b>66 12051</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HOWARD BARTH PELTZ</b>	
2. DATE AND HOUR OF DEATH <b>11-30-66 11<sup>08</sup> AM</b>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>GOULD CONVALESCENTIUM</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 6116 Belair Rd Baltimore Md</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Balt. Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>11 Walnut Avenue 21202</b>	
5. SEX <b>MALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>married</b>	8. DATE OF BIRTH <b>10 MAY 84</b>
9. AGE (In years last birthday) <b>82</b>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Selfemployed</b>	
11. BIRTHPLACE (State or foreign country) <b>Roanoke Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Peltz</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Barth</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-40-7957</b>	
17. INFORMANT <b>Mrs Gertrude E. Peltz</b>		ADDRESS <b>11 Walnut Avenue</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Atherosclerotic Cardiovascular Disease</b>		DUE TO <b>Diabetes Genitorialis</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Severe Gastrointestinal Bladder Malignancy.</b>			
19A. DATE OF OPERATION <b>11-28-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-28-66</b> to <b>11-30-66</b> , that (I) <del>last</del> saw the deceased alive on <b>11-28-66</b> and that in (my) <del>the</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> <del>did</del> <del>did not</del> view the body after death.			
23A. SIGNATURE <b>John E. Hyle</b>		23B. DATE SIGNED <b>11-30-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>John E. Hyle</b>		23D. ADDRESS <b>1527 Belair Rd Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-3-1966</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>		25B. NAME OF REGISTRAR <b>J. E. Hyle</b>	
25C. FUNERAL DIRECTOR <b>John E. Hyle</b>		ADDRESS <b>1527 Belair Rd Baltimore Md</b>	

8 48.



66 12052

BALTIMORE CITY HEALTH DEPARTMENT

66 12052

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RUTH

STEVENSON

2. DATE AND HOUR PRONOUNCED DEAD

November 29, 1966

7:40 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1604 N. Chester Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct 28-1909

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laba

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

John Stevenson

14. MOTHER'S MAIDEN NAME

Lillie Richmond

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

218-01-4910

17. INFORMANT

ADDRESS

1604 N. Chester St. Alice Stevenson

18.

331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Intracerebral Hemorrhage.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)Charles S. Petty  
Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/30/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-3-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cmt

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 2 1966

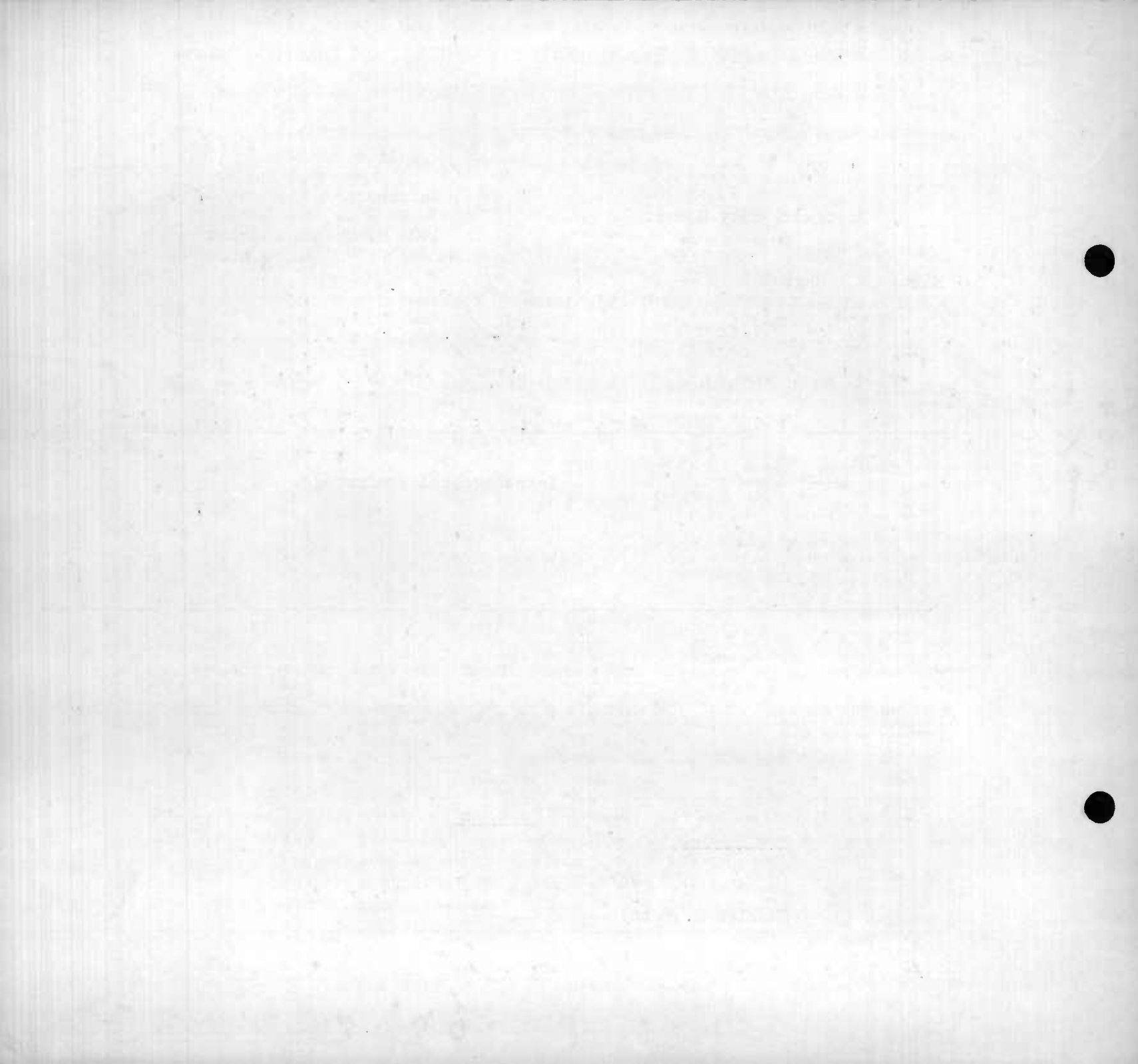
24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Gregory Wilson or Beauty

ADDRESS



H-325

66 12053

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12053

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LUTHER B. HUDGINS

2. DATE AND HOUR PRONOUNCED DEAD

11-28-66

4:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1706 LAURENS STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1706 Laurens Street 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

8-24-1903

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Luther P. Hudgins

14. MOTHER'S MAIDEN NAME

Maggie Forest

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Louch Polbi 715 Webster St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of bronchus  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-28-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-3-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

DEC 8

24B. NAME OF REGISTRAR

R. G. E. Johnson

24C. FUNERAL DIRECTOR

Sherry Wilson 1000 Beantley Rd

ADDRESS

WALLACE & GORRALL

1000

Wm. R. G.

1000

D 242		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12054	
BIRTH NO. 66 12054		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM A. DOUGLAS		2. DATE AND HOUR OF DEATH 5:15 P.M. 28 November 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 17-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. #21224		D. STREET ADDRESS (If rural, give location) 715 W. LANVALE ST. #21217			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWER, DIVORCED (specify) Single	8. DATE OF BIRTH 4-22-88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-07-8571-A		17. INFORMANT RECORDS: BCH Baltimore, Maryland #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Cerebrovascular accident DUE TO (B) ASCVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 15 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from September 16, 1966 to 28 November 1966 that (we) lost saw the deceased alive on 28 November 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel C. Hadlock		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 28 Nov 1966	
23C. PHYSICIAN'S NAME (Type) DANIEL C. HADLOCK		M.D. 23D. ADDRESS Baltimore City Hospitals 1620 McElderry St. BALT., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 12/2/66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION Baltimore		24E. DATE REC'D BY HEALTH DEPT. DEC 2 1966		24F. NAME OF REGISTRAR J. B. ...	
24G. ADDRESS 635 N. G. ...		24H. NAME OF REGISTRAR J. B. ...		24I. ADDRESS 635 N. G. ...	

27 November 1962

James C. Harlock

ASGAD

(unintelligible)

27 November 62

James C. Harlock  
120 McCreary St., Port H.  
Bristol, N.H.  
27 Nov 1962

66 12055

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12055

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Dorothy Sessomes

2. DATE AND HOUR PRONOUNCED DEAD

11/27/66 8:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

214 N. Stricker St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

3/26/1924

9. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Columbia, S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm Ross

14. MOTHER'S MAIDEN NAME

HELEN WALLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

HELEN BAPTISTE 1427 W. Fayette St

18. 002, 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary tuberculosis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/27/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/2/66

23C. NAME of CEMETERY or CREMATORY

Mt Carmel

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

DEC 2 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

James H. Hanger 638 N. Calmar St

ADDRESS

*Answer*



66 12056

BALTIMORE CITY HEALTH DEPARTMENT

66 12056

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ALICE

GAITHER

2. DATE AND HOUR PRONOUNCED DEAD

November 29, 1966

3:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY 19-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

302 N. Bruce Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

SEPARATED

8. DATE OF BIRTH

8-25-1909

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

DOMESTIC

10B. KIND OF BUSINESS OR INDUSTRY

Put family

11. BIRTHPLACE (State or foreign country)

WINNSBORO S.C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Blair Byrd

14. MOTHER'S MAIDEN NAME

Lottie Caldwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

214-22-3851

17. INFORMANT

ADDRESS

Elizabeth Bunnell 335 N. Bruce St

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/30/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/5/66

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Arbutus Baltimore Md 21227

24A. DATE REC'D BY HEALTH DEPT.

DEC 2 1966

24B. NAME OF REGISTRAR

R. E. Taylor

24C. FUNERAL DIRECTOR

M. J. Hays

ADDRESS

638 N. Gilman St

27 1-22-1909

Domestic

For

John Carpenter

John Dyer

no

RECEIVED

FOUR

FOUR

Printed by the Librarian

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12057</u>	
BIRTH NO. <u>66 12057</u>				CERTIFICATE OF DEATH	
M.E. CASE NO. <u>66 12057</u>			1. NAME OF DECEASED (Type or Print) <u>Mildred Brittingham</u>		
2. DATE AND HOUR OF DEATH <u>November 28, 1966</u> <u>10:25 P.</u> M.					
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u>			A. STATE <u>Maryland</u>		
(If not in hospital or institution, give street address or location)			B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore,</u>			D. STREET ADDRESS (If rural, give location) <u>2922 Rockrose Avenue</u>		
5. SEX <u>Female</u>			6. RACE <u>Negro</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>			8. DATE OF BIRTH <u>Oct-7, 1918</u>		
9. AGE (In years, months, days) <u>48 yrs.</u>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Alderman</u>			14. MOTHER'S MAIDEN NAME <u>Laugenia Thomas</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>212-22-9874</u>		
17. INFORMANT <u>Mr. Albert Brittingham (Husband)</u>			ADDRESS <u>SAME</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO <u>Diabetes mellitus with acidosis</u>		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>None</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>No</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>November 25, 1966</u> to <u>November 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>November 28, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James D. Carr</u>			23B. DATE SIGNED <u>11-29-66</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. James Carr</u>			23D. ADDRESS <u>1514 Division Street-Baltimore 17, Maryland</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>12/2/66</u>		
24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1966</u>			25B. NAME OF REGISTRAR <u>Herbert E. Nutter-3035 W. North Ave.</u>		
25C. FUNERAL DIRECTOR ADDRESS <u>Herbert E. Nutter-3035 W. North Ave.</u>					

5222 Lockwood Avenue

St. Ann.

Harford

Harford

Harford

North Carolina

General Nelson

1010

15-40-4074 Mr. Albert H. H. H. H.

No

November 25

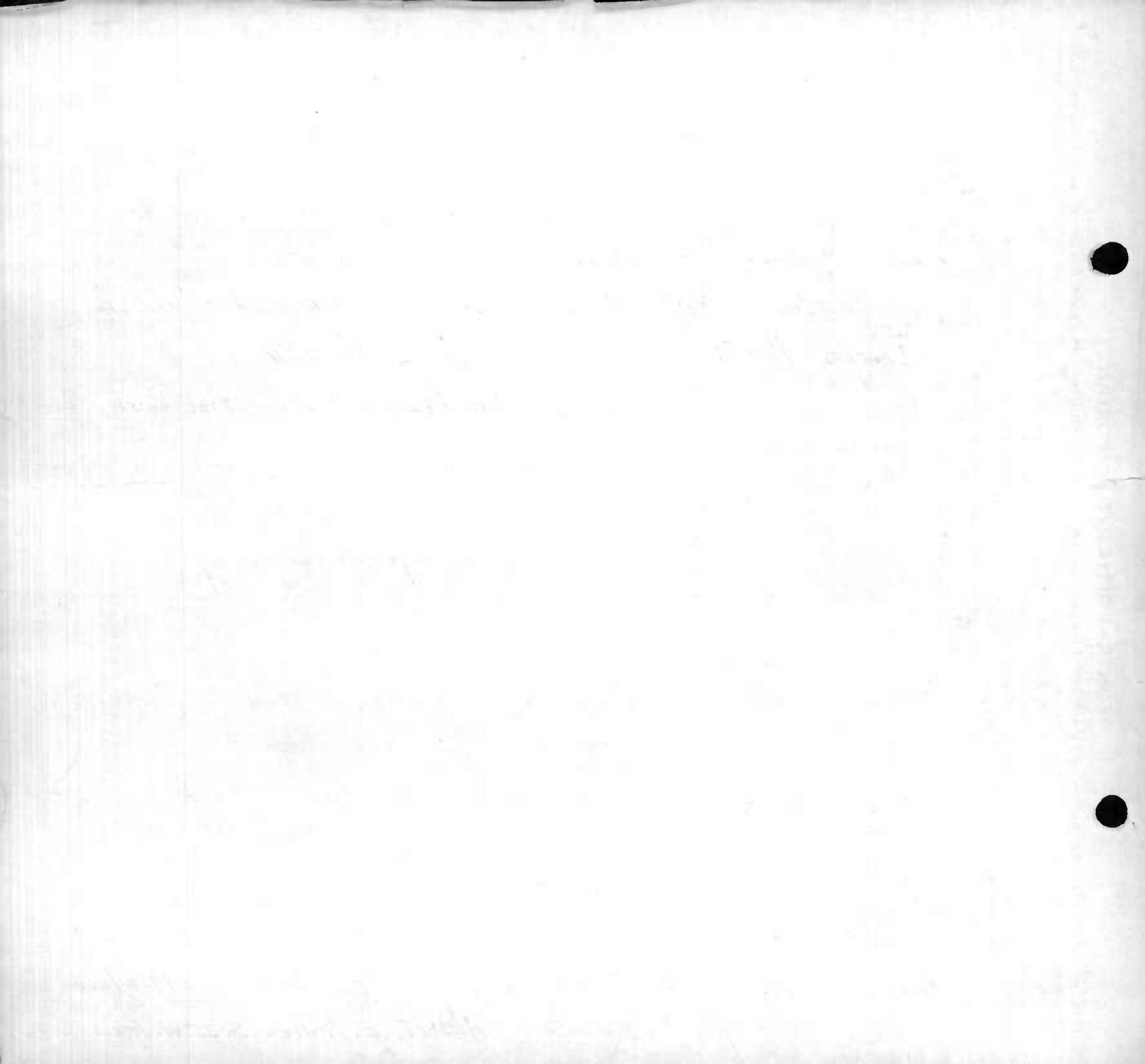
November 25

X

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 12058	
BIRTH NO. 66 12058		CERTIFICATE OF DEATH		Registered No. 66 12058	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM HURTT		2. DATE AND HOUR OF DEATH 11/29/66 9:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 14-03		D. STREET ADDRESS (If rural, give location) 2113 McCullah St. #17	
5. SEX MALE	6. RACE Colored	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED, Widowed)	8. DATE OF BIRTH 3/17/10	9. AGE (In years lost birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL HANDLER		10B. KIND OF BUSINESS OR INDUSTRY POST OFFICE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME Charles Hurtt		14. MOTHER'S MAIDEN NAME LULA GREEN		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-20-4640		17. INFORMANT Mrs. Henry A. Rawlings 2036 Ruxton Ave	
18. 422.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Congestive Heart Failure Prob. Myocardioopathy		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/28/66 1966 to 11/29 1966, that (I) (we) last saw the deceased alive on 11/29/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gerardo Ypil M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/29/66	
23C. PHYSICIAN'S NAME (Type) GERARDO YPIL JR. M.D.		23D. ADDRESS SINAI HOSPITAL BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/66		24C. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem	
24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1966		25B. NAME OF REGISTRAR H. E. Nutter		25C. FUNERAL DIRECTOR HERBERT E. NUTTER 3035 W. NORTH AVE	



66 12059

BALTIMORE CITY HEALTH DEPARTMENT

66 12059

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

THEODORE

BROWN

2. DATE AND HOUR PRONOUNCED DEAD

November 27, 1966

10:50 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

632 Sarahann Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

11/10/1904 62

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mamion Harrison 949 W. Fayette St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 28, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

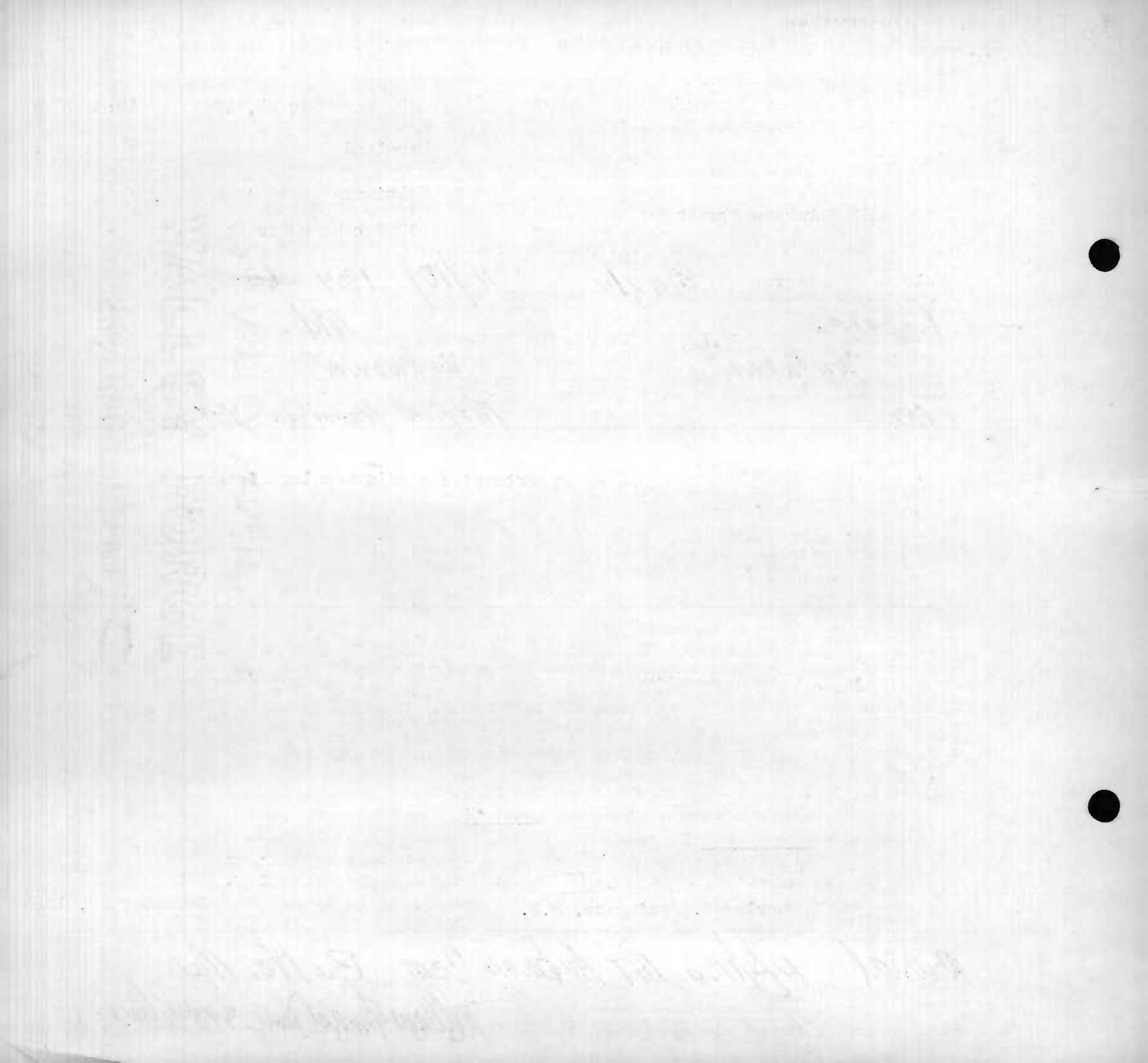
24A. DATE REC'D BY HEALTH DEPT

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Burial 12/2/66 Mt. Auburn Cem. Balt. Md.  
DEC 2 1966 D. G. E. Johnson Williams Funeral Home 3911 Scholander St.

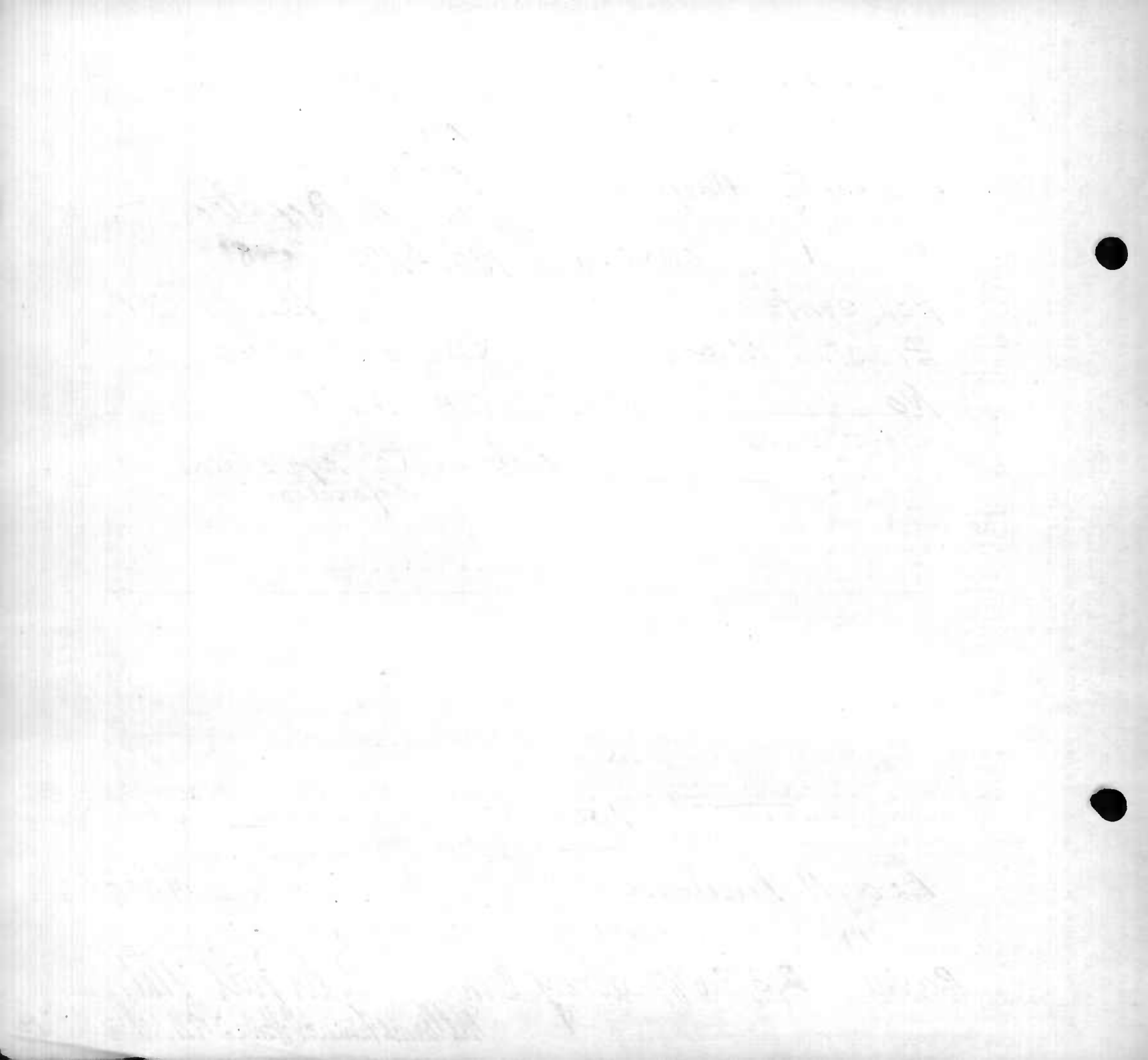




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12060				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12060	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LEWIS, GEORGIA</b>				2. DATE AND HOUR OF DEATH <b>Nov. 30, 1966   6:30 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 18-01</b>			
				D. STREET ADDRESS (If rural, give location) <b>418 N. Appleton St.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>April 23, 1908</b>	9. AGE (in years last birthday) <b>58</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Erasmus Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Scarborough</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ER chart</b>		ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Prob. acute myocardial infarction</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO				(B) DUE TO		(C) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 30 1966</b> to <b>Nov 30 19 66</b> , that (I) (we) last saw the deceased alive on <b>Nov. 30 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Garry N. Rosenbaum</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/30/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>GARRY N. ROSENBAUM</b> M.D.				23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/3/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>W. H. Calvary Cem.</b>		24D. LOCATION (City, town or county) (State) <b>Cedar Hill Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>		25B. NAME OF REGISTRAR <b>W. H. Calvary</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>319 N. Schroeder St.</b>	



1  
M-600

66 12061

BALTIMORE CITY HEALTH DEPARTMENT

66 12061

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Ollie Lee Moore

2. DATE AND HOUR PRONOUNCED DEAD

11/25/66 11:45 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

12-03

D. STREET ADDRESS (If rural, give location)

2508 Guilford Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Oct. 6, 1922

9. AGE (In years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Kosher

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Huntsville, Ala.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Moore

14. MOTHER'S MAIDEN NAME

Larthular Beasley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; if yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT,

ADDRESS

Mr. Willie Moore 2021 N. Bentall

18. E982X1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Stab wound of chest and brain  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

in front of 434 E. 21st. St.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
8 18 66 11:10p

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed repeatedly with ice pick

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/26/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Nov. 30, 1966

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county) (State)  
Westport (Baltimore) Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 2

1966

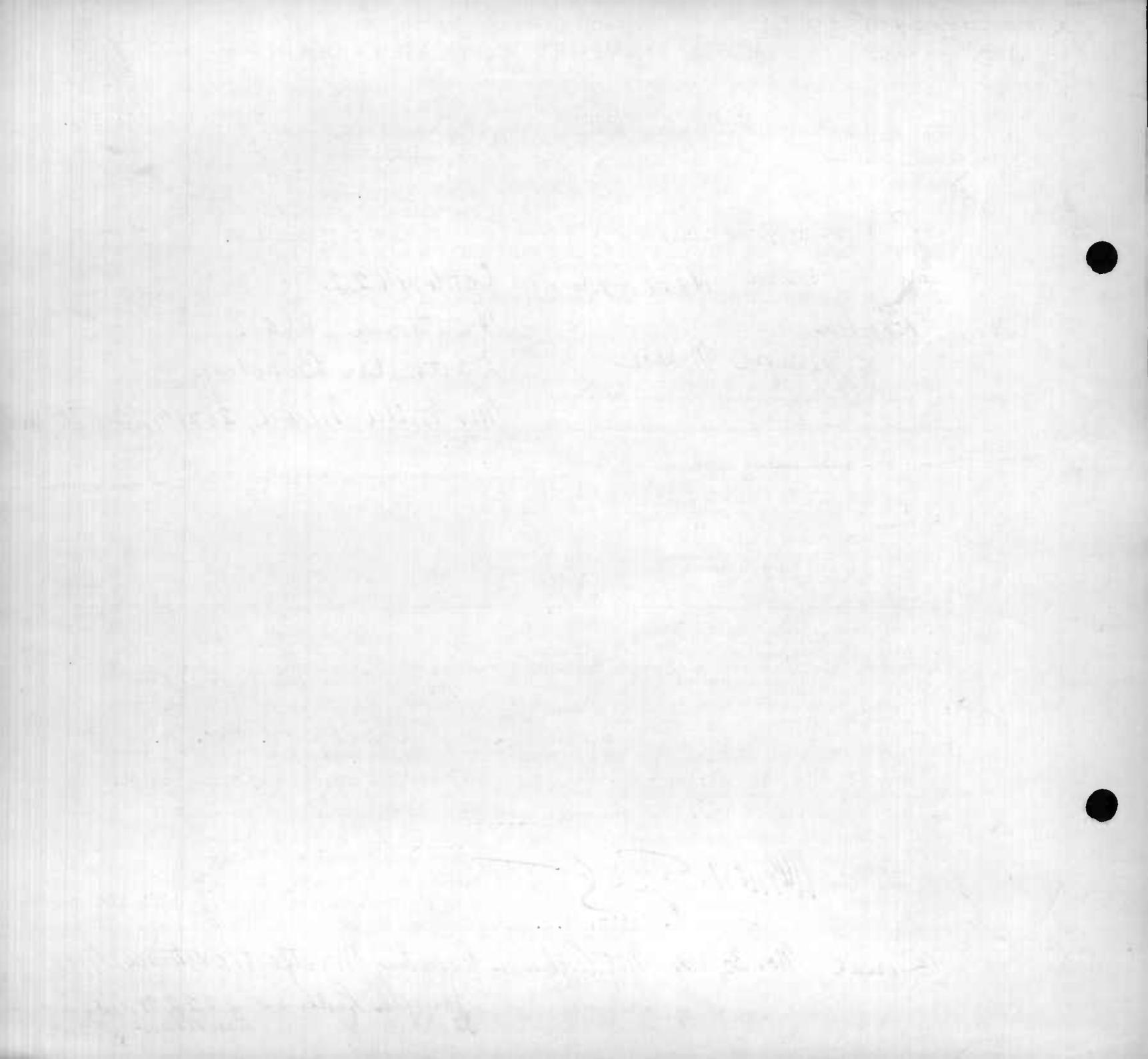
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Joseph L. Reiss

ADDRESS

2222 N. Naylor Ave  
Baltimore, Md.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12062				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12062	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mary Betha</i>				2. DATE AND HOUR OF DEATH <i>27 Nov 1966 1:10 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE <i>Maryland</i>			
<i>31 Baltimore City Hospitals</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
<i>4940 Eastern Avenue, Baltimore, Md. 21224</i>				D. STREET ADDRESS (If rural, give location) <i>2851 Prospect St. 21216</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>		8. DATE OF BIRTH <i>3/29/01</i>	9. AGE in years (last birthday) <i>65</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Stacy Green</i>				14. MOTHER'S MAIDEN NAME <i>Betty</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>242-09-0127</i>		17. INFORMANT <i>Records: BCH-4940 Eastern Avenue</i>		ADDRESS <i>21224</i>	
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <i>ASCVD</i>		<i>Years.</i>	
ANTECEDENT CAUSES				(B) DUE TO <i>Chronic Brain Synd</i>		<i>Years</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <i>Chayne Stokes Resp</i>		<i>1 day</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that <del>the</del> (this hospital) attended the deceased from <i>6:00 AM</i> <i>1965</i> to <i>27 Nov 1966</i> , that <del>the</del> (we) lost saw the deceased alive on <i>27 Nov 1964</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) <del>did not</del> view the body after death.							
23A. SIGNATURE <i>Dudley A. Raine Jr.</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>27 Nov 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dudley A. Raine Jr.</i>				23D. ADDRESS <i>4940 Eastern Avenue, Baltimore, Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec 1, 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Auburn Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 2 1966</i>		25B. NAME OF REGISTRAR <i>Joseph R. Pass</i>		25C. FUNERAL DIRECTOR ADDRESS <i>2222 W. North Ave</i>			

Stony Green

Baltimore City Hospitals

North Carolina  
3/22/01  
5821 Prospect St  
1211  
Maryland

Chapman State Bank  
Chesapeake, Va  
A2C V D

Dr. Henry A. Kniff

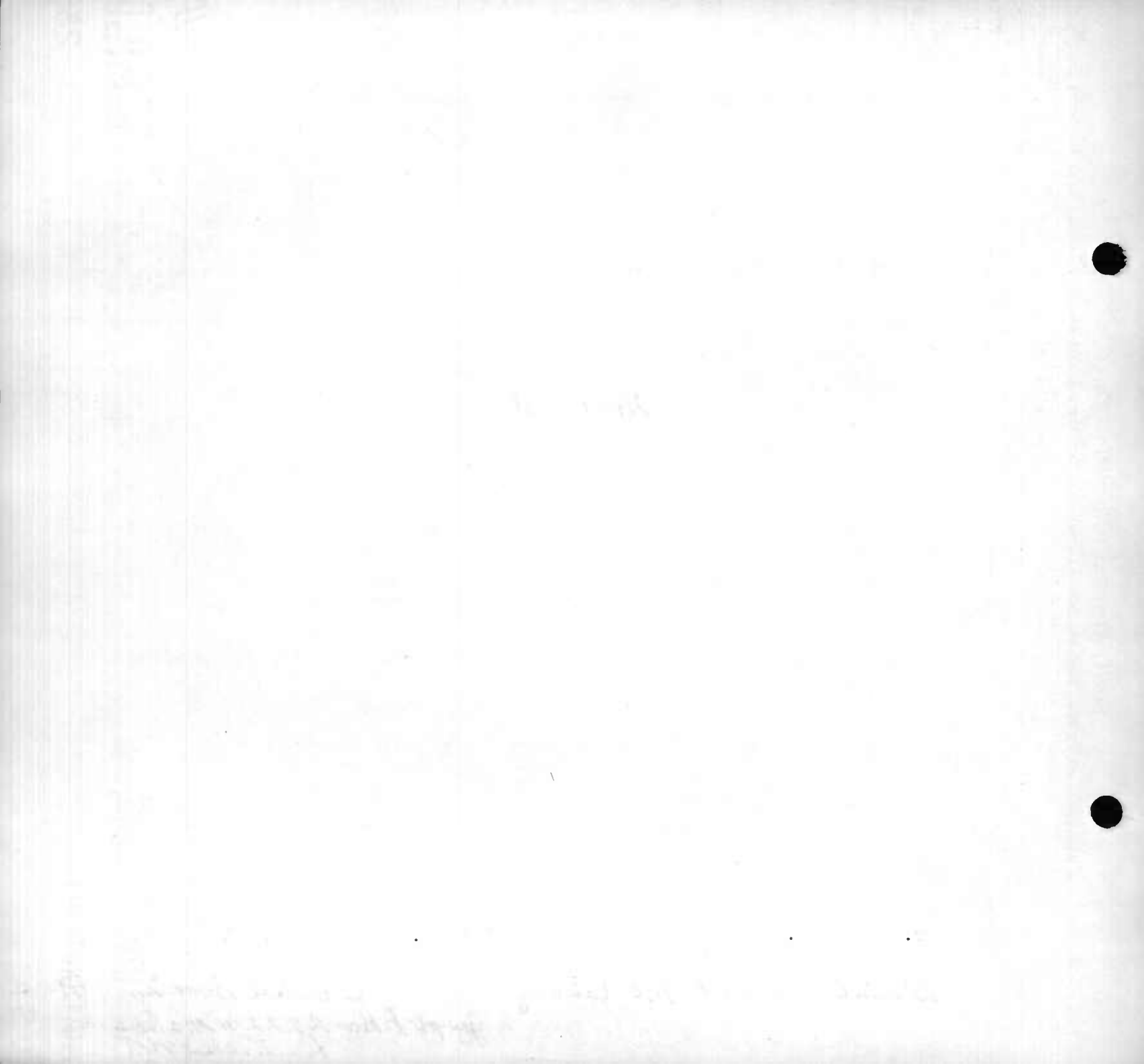
25 Nov 2 1900

Page 9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12063</u>	
BIRTH NO. <u>66 12063</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Dullock Mary</u>		2. DATE AND HOUR OF DEATH <u>11/29/66</u> <u>2:00 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Dukeland nursing Home</u> <u>1501 Dukeland St.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Maryland</u> <u>2301</u>			
		D. STREET ADDRESS (If rural, give location) <u>1027 Peach St.</u>			
5. SEX <u>Female</u>	6. RACE <u>negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>11/1/95</u>	9. AGE (In years lost birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Ed. Harris (Dec.)</u>		14. MOTHER'S MAIDEN NAME <u>Sue</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-14-2281</u>		17. INFORMANT <u>Dukeland nursing Home</u> ADDRESS <u>1501 Dukeland Street</u>	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CHRONIC MYOCARDITIS</u> DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> 19 <u>66</u> to <u>11-29</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-29</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas W. Harris</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>11-29-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Thomas W. Harris</u>		23D. ADDRESS M.D. <u>1824 W. Franklin Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12-3-66</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary</u>		24D. LOCATION (City, town, or county) (State) <u>Cedar Hill Brooklyn Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Joseph L. King</u>		25C. FUNERAL DIRECTOR <u>2222 N. Nankin Baltimore, Md.</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 12064</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 1.5em;">66 12064</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">James Robert Kenny</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">November 30, 1966</span> <span style="font-size: 1.2em;">Nov. 29 1966 1:30 A.M.</span>	
<b>CERTIFICATE AMENDED</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">2826 Westwood Avenue</span>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">1506</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2826 Westwood Avenue</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Colored</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Sept. 6, 1920</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">46</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Salesman</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Edgecombe, G. C. Ghana</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">General Kenny</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Henrietta Perry</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes</span> <span style="font-size: 1.2em;">WW II</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">219-09-5487</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Sarah Kenny</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Coronary Occlusion</span>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Coronary Sclerosis</span>		ADDRESS <span style="font-size: 1.2em;">2826 Westwood Ave.</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">April 1964</span> to <span style="font-size: 1.2em;">Nov. 29 1966</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Nov. 29, 1966</span> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">M. Paul Beverly</span>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">M. Paul Beverly</span>				23D. ADDRESS <span style="font-size: 1.2em;">5420 York Rd Baltimore 12 MD</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">Dec 5, 1966</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore National Cemetery Baltimore Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 2 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. [unclear]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Joseph L. Russ</span>	
ADDRESS <span style="font-size: 1.2em;">2222 N. North Ave. Baltimore, Md.</span>					

12/8/66 - Letter from Dr. Paul Byerly, 5820 York Road. Letter dated, 12/7/66.

JPC.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12065	
66 12065					
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Lester E. Bey			11-29-66 5 <sup>39</sup> PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIV. HOSP. BALTO. 1, MD.			A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 3211 WOODLAND AVE.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost <small>lost</small> )	10. Under 1 Yr. Months Days
M	N	W	7-15-05	61	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				Georgia	
13. FATHER'S NAME			14. MOTHER'S M maiden NAME		
Robert Bey			Martha		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
-			218-05-2854		PEARL FRACTION S/A
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
44-3X1			Cerebrovascular disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO Hypertensive arteriosclerotic cardiovascular disease		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(B) DUE TO		
(C)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/28/66 to 11/29/66, that (I) (we) last saw the deceased alive on 11/29/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Stuart L. Fine		23B. DATE SIGNED 11-29-66	
23C. PHYSICIAN'S NAME (Type) STUART L. FINE		23D. ADDRESS UNIV. HOSP. BALTO. 1, MD.		23E. FUNERAL DIRECTOR MORTON D. F.H.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-3-66		Mt. Auburn Cem. Balto.	
24D. LOCATION (City, town, or county)		24E. STATE		24F. ADDRESS	
Md.		Md.		1701 Laurens St.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 2 1966		MORTON D. F.H.		1701 Laurens St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12066		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12066	
1. NAME OF DECEASED (Type or Print) <b>Annie Shoultz</b>			2. DATE AND HOUR OF DEATH <b>11-30-66</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00803 Harlem Ave.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>803 Harlem Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>9-25-1902</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Millersville, Md.</b>	
13. FATHER'S NAME <b>christopher Joyce</b>			14. MOTHER'S MAIDEN NAME <b>Mary Jane Chatman</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-30-3322</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy Gwynn 803 Harlem Avenue</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion of mca</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertension</b> <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/1/66</b> 19 to <b>12/1/66</b> 19, that (I) (we) last saw the deceased alive on <b>8/1/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. C. WELCOME</b>				23B. DATE SIGNED <b>12/1/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. C. WELCOME</b>				23D. ADDRESS <b>1106 HARLEM AVE.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-5-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>	
24D. LOCATION <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>			
25B. NAME OF REGISTRAR <b>Morton &amp; Dyett F. H.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1701 Laurens</b>			

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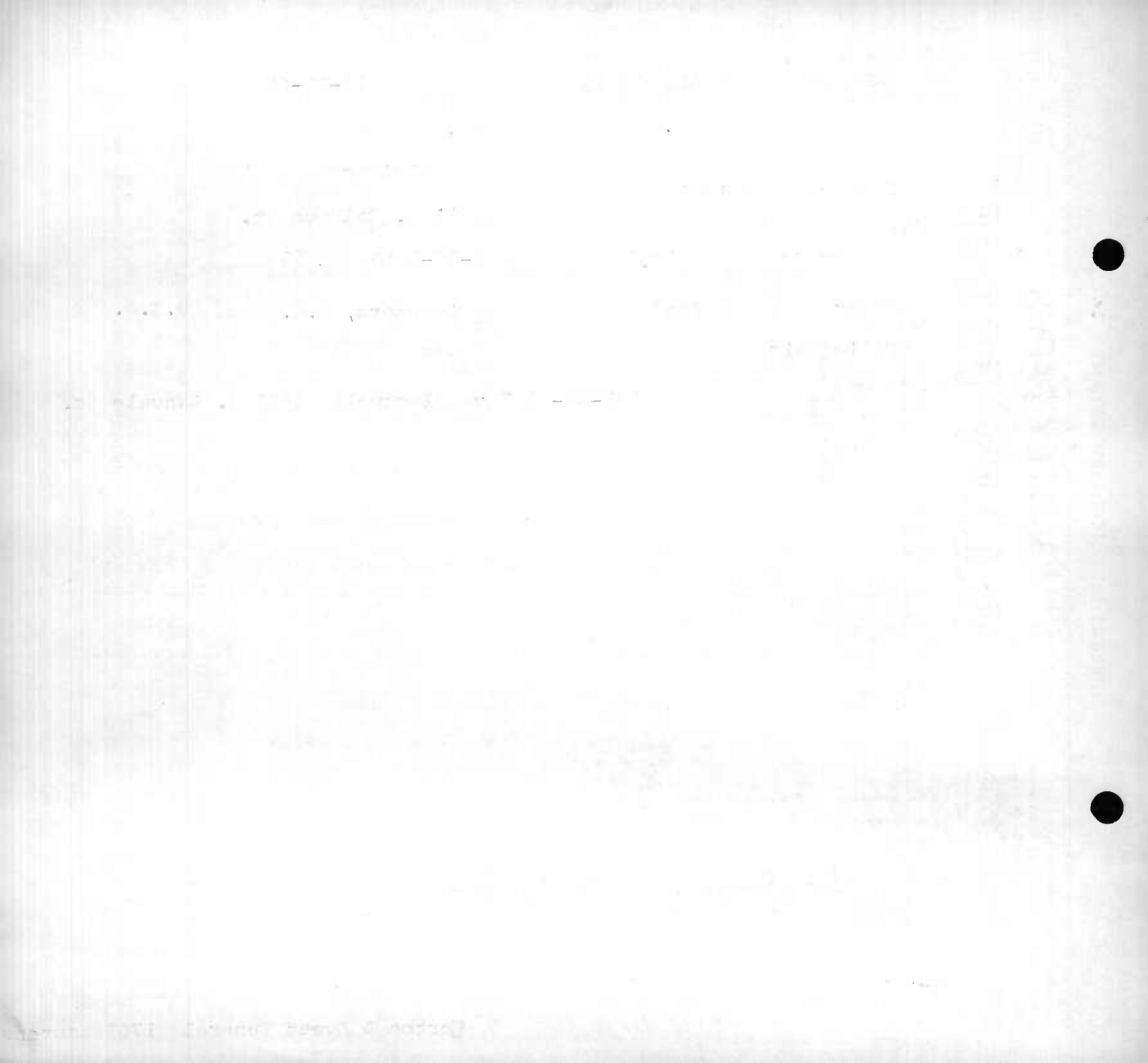
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 12067	
BIRTH NO.				66 12067	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
WILLIAM WILLIE FAIR				11-29-66 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
46 Lutheran Hospital				Md.	
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
M Negro Single				Baltimore	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				D. STREET ADDRESS (If rural, give location)	
Helper				431 N. Calhoun St.	
10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH 9. AGE (In years last birthday)	
Food				2-15-1910 56	
13. FATHER'S NAME				11. BIRTHPLACE (State or foreign country)	
Willie Fair				Winnsboro, S.C.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
247-09-9167				Eva Blackwell 1903 W. Lanvale St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH	
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Coronary Thrombosis 1 day	
(B) Aortic valve E. thickening 2 years				(C) Cardiac arrest 9/8/65	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/1/68 1968 to 11/20 1968, that (I) (we) last saw the deceased alive on 11/20 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				12/1/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M.D.				M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12-4-66		Grubbs Mem. Pl.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 2 1966		[Signature]		Borton & Dyett Funeral	
24D. LOCATION (City, town, or county) (State)		ADDRESS			
Md.		1701 Laurens			





1  
M-63

BALTIMORE CITY HEALTH DEPARTMENT

66 12068

66 12068

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ALEXANDER

MARTIN

2. DATE AND HOUR PRONOUNCED DEAD

November 30, 1966

2:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31 City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1938 W. Mosher Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

12-7-1921

9. AGE (In years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Revere Copper & Brass Portsmouth, Va.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

ALEXANDER MARTIN

14. MOTHER'S MAIDEN NAME

EMMA ROBERTS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

224-16-3237 Mrs. Bethoria Martin 1938 W. Mosher

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Multiple Myocardial Infarcts  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic and Hypertensive  
DUE TO Cardiovascular Disease

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S

NAME (Type) Rudiger Breiteneker, MD.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

12/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

15/10/2015

48-20-76

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

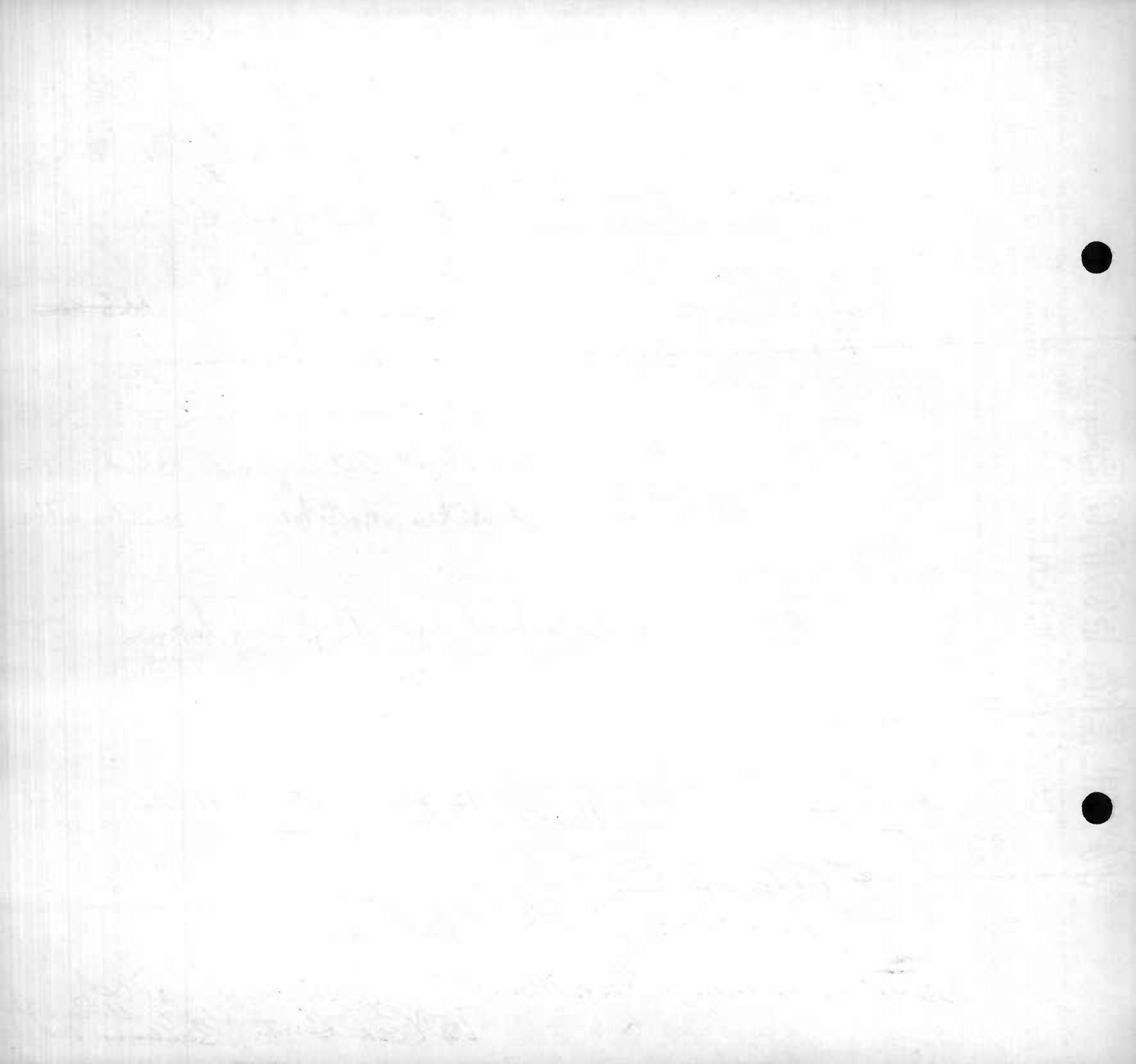
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12069	
1. NAME OF DECEASED (Type or Print) <b>ELLA MAE DARDEN</b>				2. DATE AND HOUR OF DEATH <b>11-30-66 11:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE MARYLAND 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1401 MOSHER STREET</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-17-19</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
13. FATHER'S NAME <b>COLUMBUS Battle</b>			14. MOTHER'S MAIDEN NAME <b>MINNIE Proctor</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RECORDS BCH 4940 EASTERN AVENUE</b>	
18. <b>241X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>cardiac arrest</b> DUE TO (B) <b>severe refractory asthma</b> DUE TO (C)	
INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>  <b>5 weeks - severe over 2 days</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>66</b> to <b>11/30</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/30</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Terry Ersel Gagon</b>				23B. DATE SIGNED <b>11/30/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Terry Ersel Gagon</b>				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-4-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>West Heaven Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Wilson, North Carolina</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>		25B. NAME OF REGISTRAR <b>George Keelson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1348 N. Calhoun St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

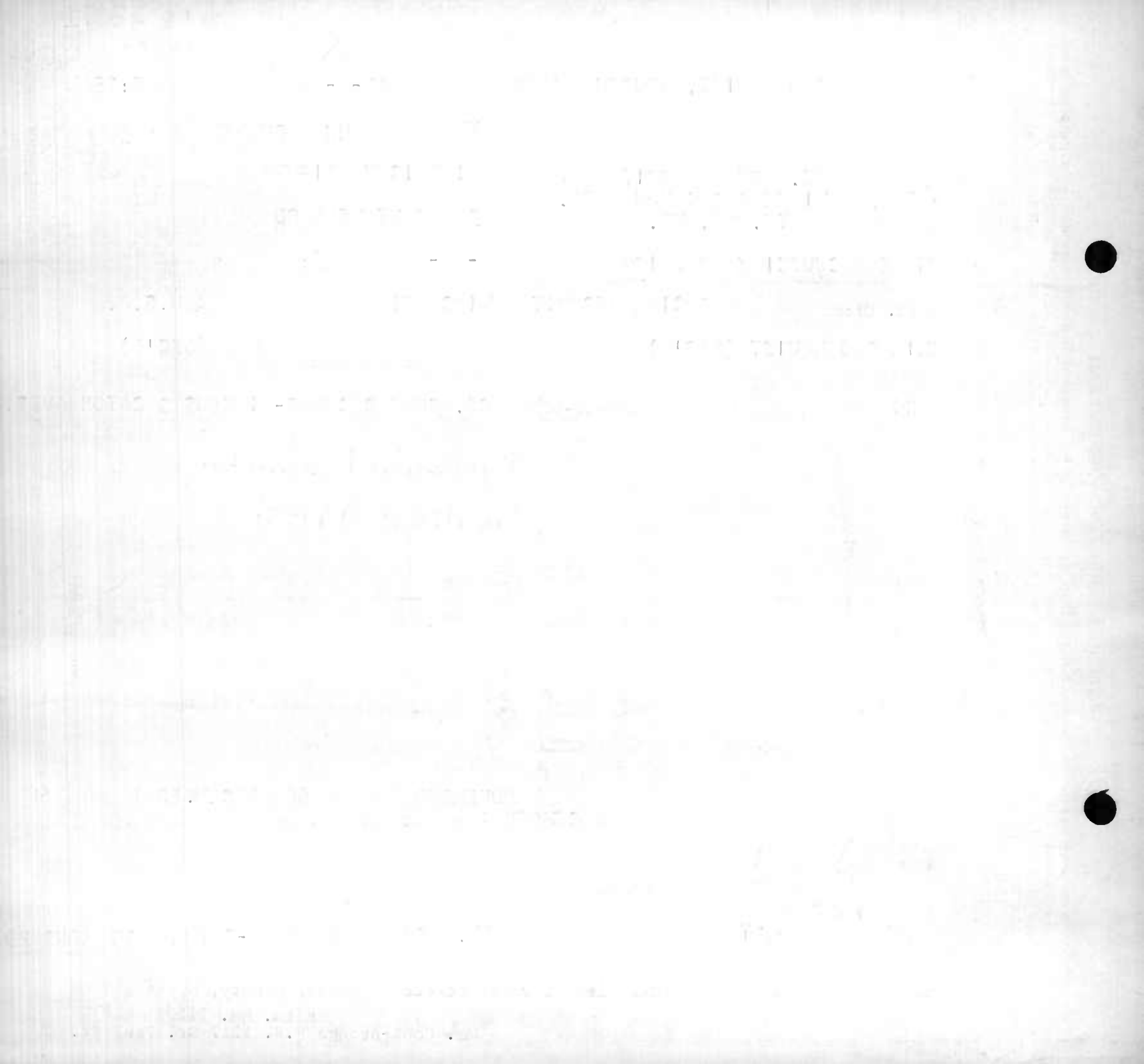
BIRTH NO. 66 12070		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12070	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Harval Baptist</i>		
2. DATE AND HOUR OF DEATH <i>11/26/66</i> <i>930 A.M.</i>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1205</i>			5. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
6. STREET ADDRESS (If rural, give location) <i>2019 Charles St.</i>			7. FATHER'S NAME <i>Unknown - Baptist</i>		
8. SEX <i>M</i>			9. RACE <i>W</i>		
10. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>			11. DATE OF BIRTH <i>3-18-79</i>		
12. AGE (In years last birthday) <i>87</i>			13. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Prof. Ice Skater</i>			15. BIRTHPLACE (State or foreign country) <i>Candana</i>		
16. KIND OF BUSINESS OR INDUSTRY			17. MOTHER'S MAIDEN NAME <i>Unknown</i>		
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			19. SOCIAL SECURITY NO.		
20. INFORMANT <i>Joseph Brown</i>			21. ADDRESS <i>2019 Charles St Baltimore Md</i>		
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Generalized arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>Several months</i>			23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>diabetes mellitus - several months</i>		
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Bilateral upper thigh amputations 12 yrs ago</i>			25. MEDICAL CERTIFICATION		
26. DATE OF OPERATION <i>0</i>			27. CONDITION FOR WHICH OPERATION WAS PERFORMED		
28. AUTOPSY? (Yes or No) <i>No</i>			29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
32. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
34. HOW DID INJURY OCCUR?			35. I certify that (I) (this hospital) attended the deceased from <i>12-2-1965</i> to <i>11-26-1966</i> , that (I) (we) last saw the deceased alive on <i>11-25-1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		
36. SIGNATURE <i>E. Ellsworth Cook</i>			37. DATE SIGNED <i>11-26-66</i>		
38. PHYSICIAN'S NAME (Type) <i>2431 E. Ellsworth Cook</i>			39. ADDRESS <i>2431 Maryland Ave</i>		
40. CREMATION, REMOVAL (Specify) <i>Cremation</i>			41. DATE <i>12-1-1966</i>		
42. NAME OF CEMETERY or CREMATORY <i>Green Mount</i>			43. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		
44. DATE REC'D BY HEALTH DEPT. <i>DEC 2 1966</i>			45. NAME OF REGISTRAR <i>1217 St Paul St</i>		
46. FUNERAL DIRECTOR <i>1217 St Paul St Baltimore Md</i>			47. ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12071		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12071	
M.E. CASE NO.		CERTIFICATE OF DEATH		1	
1. NAME OF DECEASED (Type or Print)		BLOOMQUIST, REUBEN ELWOOD		2. DATE AND HOUR OF DEATH 12-1-66 5:25AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO. 29, MD.		A. STATE MD B. COUNTY ANNE ARUNDEL Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) LINTHICUM HEIGHTS 32-00 D. STREET ADDRESS (If rural, give location) 504 SOUTHWELL RD		MALE CAUCASIAN MARRIED	
6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 8-14-07	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov't. Clerk		10B. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY		9. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.		11 Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME EMIL BLOOMQUIST (DEC'D)		14. MOTHER'S MAIDEN NAME Julina Sural (DEC'D)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 219-42-6031		17. INFORMANT ST. AGNES RECORDS-WILKENS & CATON AVES.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Myocardial Infarction (B) Cardiac Arrest (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 19 66 to DECEMBER 1 19 66, that (I) (we) last saw the deceased alive on DECEMBER 1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE B HOOTON		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) A		23D. ADDRESS M.O. ST. AGNES HOSPITAL -CATON & WILKENS 29			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/5/66		24C. NAME of CEMETERY or CREMATORY Lake View Memorial Cemetery	
24D. LOCATION (City, town, or county) (State) Carroll County, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 2 1966		25B. NAME OF REGISTRAR Wm Cook-Brooks F.H. 1217 St. Paul St.	
25C. FUNERAL DIRECTOR Balto. Md. 21202		25D. ADDRESS			

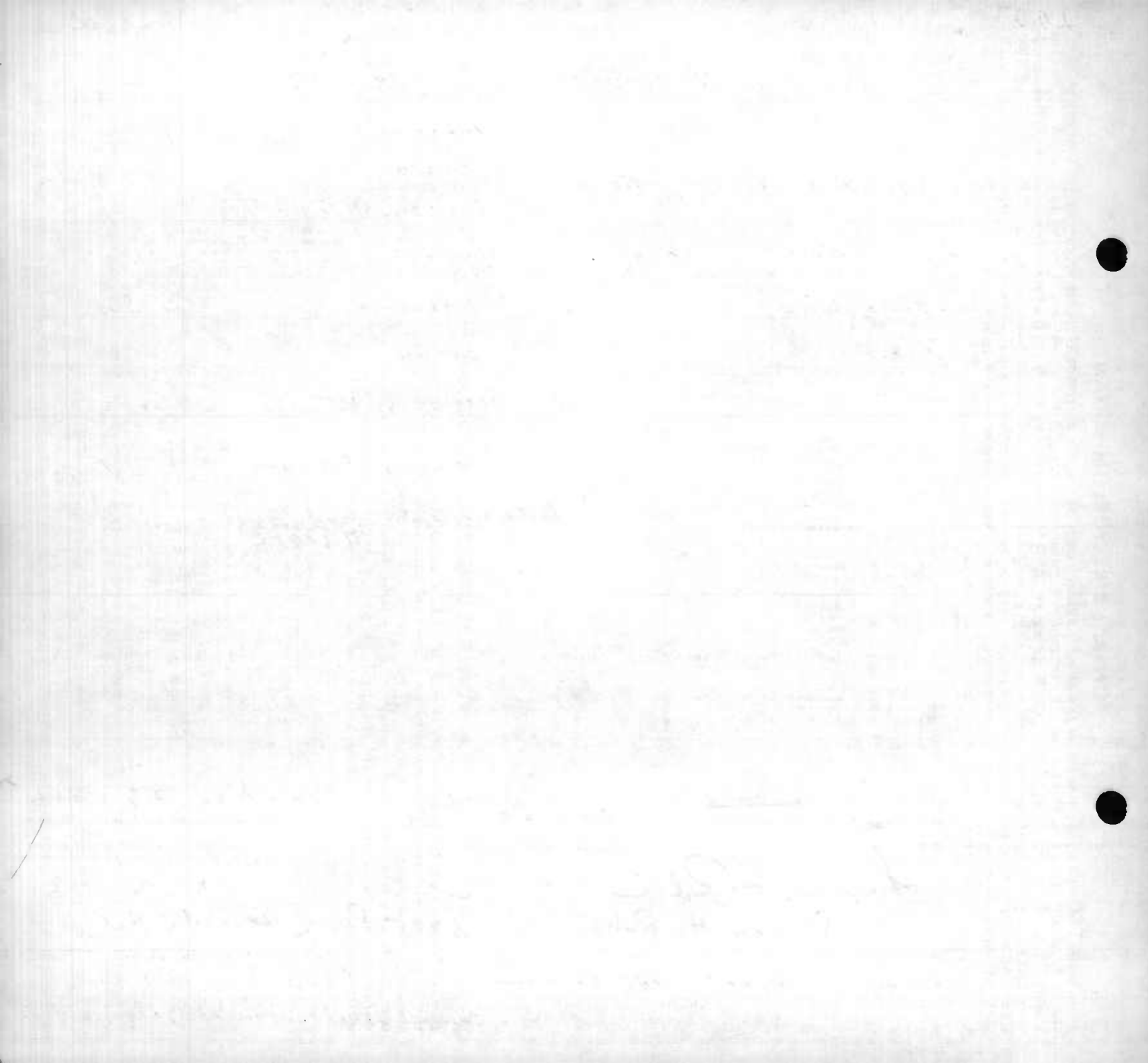




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12072					CERTIFICATE OF DEATH		Registered No. 66 12072		
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <b>DINAH L. NEWHOUSE</b>					Nov. 29, 1966 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 MT. SINAI NURSING HOME</b>					A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto. Co.</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>				
					D. STREET ADDRESS (If rural, give location) <b>5 CRISMER COURT TR</b>				
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>3/16/1893</b>		9. AGE (In years last birthday) <b>73</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>BERLE</b>					14. MOTHER'S MAIDEN NAME <b>ETTA</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>BERNARD C. NEWHOUSE - SAME</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>422.11</b>					CAUSE OF DEATH (A) <b>Pulmonary edema</b> DUE TO (B) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b> <b>Several years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>66</b> to <b>Nov 29</b> 19 <b>66</b> , that (I) <del>was</del> last saw the deceased alive on <b>Nov 29</b> 19 <b>66</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.									
23A. SIGNATURE <b>Seymour H. Rubin</b>							23B. DATE SIGNED <b>Nov 30 1966</b>		
23C. PHYSICIAN'S NAME (Type) <b>Seymour H. Rubin</b>							23D. ADDRESS <b>5415 Park Heights Ave.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/1/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT CARMEL</b>			24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Steffens</b>			25C. FUNERAL DIRECTOR ADDRESS <b>Sylvan S. Lewis &amp; Son, Inc - 3319 Olympia Ave.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12073</u>	
BIRTH NO. <u>66 12073</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>LOUIS CAPULLI</b>		2. DATE AND HOUR OF DEATH <b>Dec. 2, 1966</b> <u>11<sup>10</sup>A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>2532 Harford Road</b>		A. STATE <b>Maryland</b> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #18</b> <u>9-07</u>			
		D. STREET ADDRESS (If rural, give location) <b>2532 Harford Road</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>Apr. 20, 1891</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>tailor (Retired)</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Abruzzi, Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Berardino Capulli</b>		14. MOTHER'S MAIDEN NAME <b>Palma ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-01-8400A</b>		17. INFORMANT ADDRESS <b>Mrs. Anna Capulli 2532 Harford Rd., Balto.</b>	
18. <u>334X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cerebral Arteriosclerosis</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>27 Jan</u> 19 <u>65</u> to <u>2 Dec</u> 19 <u>66</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>25 Nov</u> 19 <u>66</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>2 Dec 66</u>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Anderson M. Renick, Jr.</b>		23D. ADDRESS <b>1010 St. Paul St., Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/5/66.</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>		25B. NAME OF REGISTRAR <b>Leonard J. Rueck, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Baltimore, Md.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12074				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12074	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHNSON, RICHARD ALWARD</b>				2. DATE AND HOUR OF DEATH <b>December at 1:45 PM 1966 M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE COUNTY JOPPA</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>JOPPA BALTIMORE COUNTY</b>			
				D. STREET ADDRESS (If rural, give location) <b>OLD JOPPA ROAD 2314 53-00</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>4-17-02</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRAINER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HORSES</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RICHARD ALWARD JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH GORMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-24-2666</b>		17. INFORMANT <b>DR. RALPH G. HILLS, 18 E. EAGER ST.</b>	
18. <b>602X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic nephrolithiasis + pyelonephritis</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-8</b> 19 <b>66</b> to <b>12-1</b> 19 <b>66</b> . that (I) (we) last saw the deceased alive on <b>12-1</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Fred J. Bjornsson</b> M.D.				23B. DATE SIGNED <b>12-1-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>FRIEDTJOFUR BJORNSSON</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/3/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>		25B. NAME OF REGISTRAR <b>Robert S. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Baltimore 12, Md.</b>	

Staff of the Department of the Interior  
Washington, D.C.

Letter of the Secretary of the Interior  
to the Secretary of the Army

Re: The proposed construction of a  
dam on the Colorado River

Trainer, Horses  
Elizabeth G. Gurnea

Enclosed for the Secretary of the Army  
is a copy of the letter of the Secretary of the Interior

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12075		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12075	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) John Clement Tarsel		
2. DATE AND HOUR OF DEATH November 30, 1966 10:00 P. M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION 00 731 Sheridan Ave.		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland Baltimore 27-10 731 Sheridan Ave.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/20/1892	9. AGE (In years lost birthday) 74	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Watchman		10B. KIND OF BUSINESS OR INDUSTRY Security		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Tarsel			14. MOTHER'S MAIDEN NAME Anna Slammok		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 205-09-6440		17. INFORMANT Mr. & Mrs. Anthony J. Tarsel, 731 Sheridan Ave	
18. I 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) Cerebrovascular accident DUE TO (B) generalized atherosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 minutes years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 19 66 to Nov 19 66, that (I) (we) last saw the deceased alive on June 9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Palmisano			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/2/66
23C. PHYSICIAN'S NAME (Type) Joseph F. Palmisano			23D. ADDRESS M.D. 6608 LochRaven Blvd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/1966		24C. NAME of CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 2 1966		25B. NAME OF REGISTRAR R. E. Tarsel	
25C. FUNERAL DIRECTOR H. V. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.					

General Secretary  
Principal Administrator

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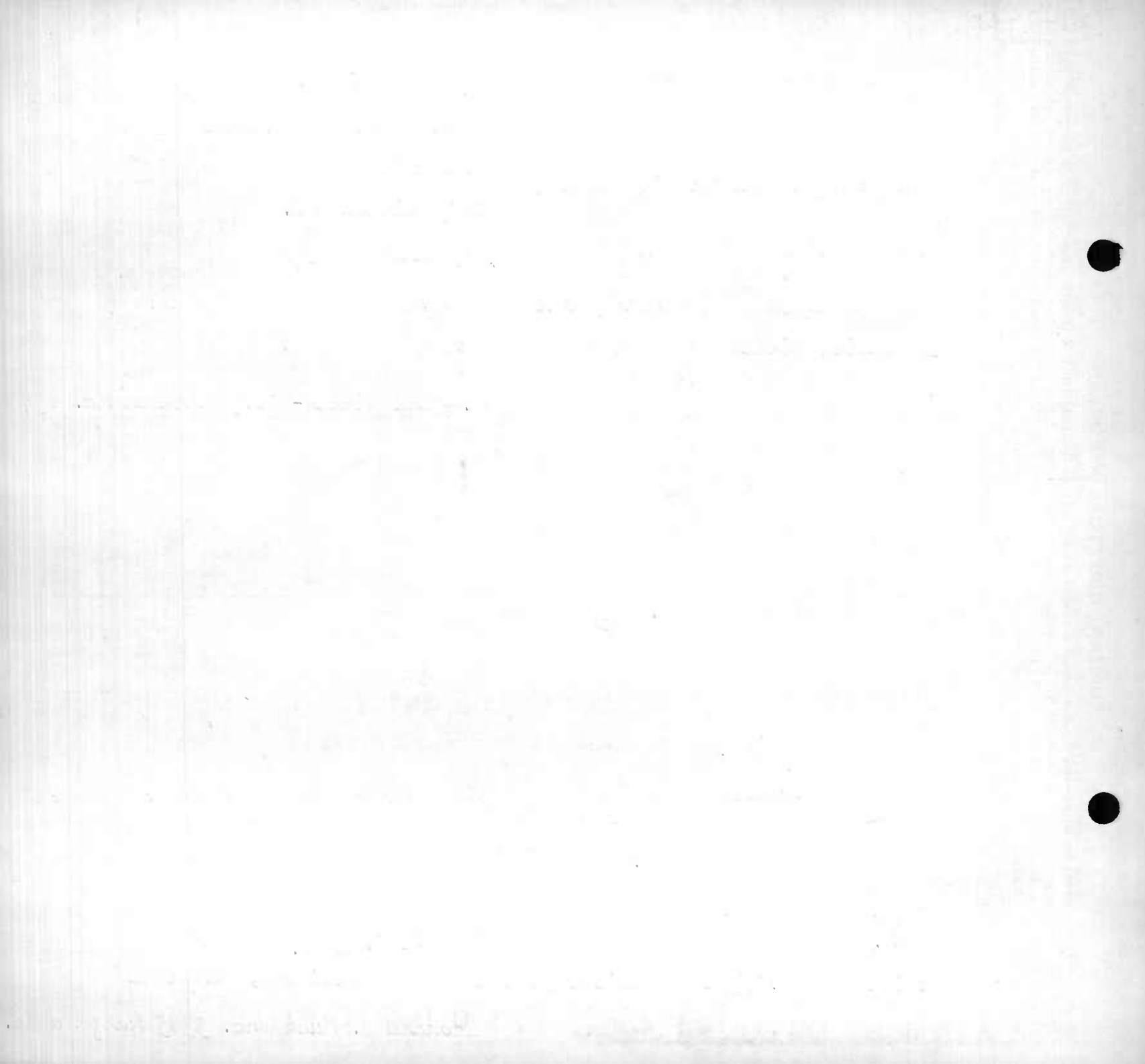
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# FUNERAL DIRECTOR: IMPORTANT

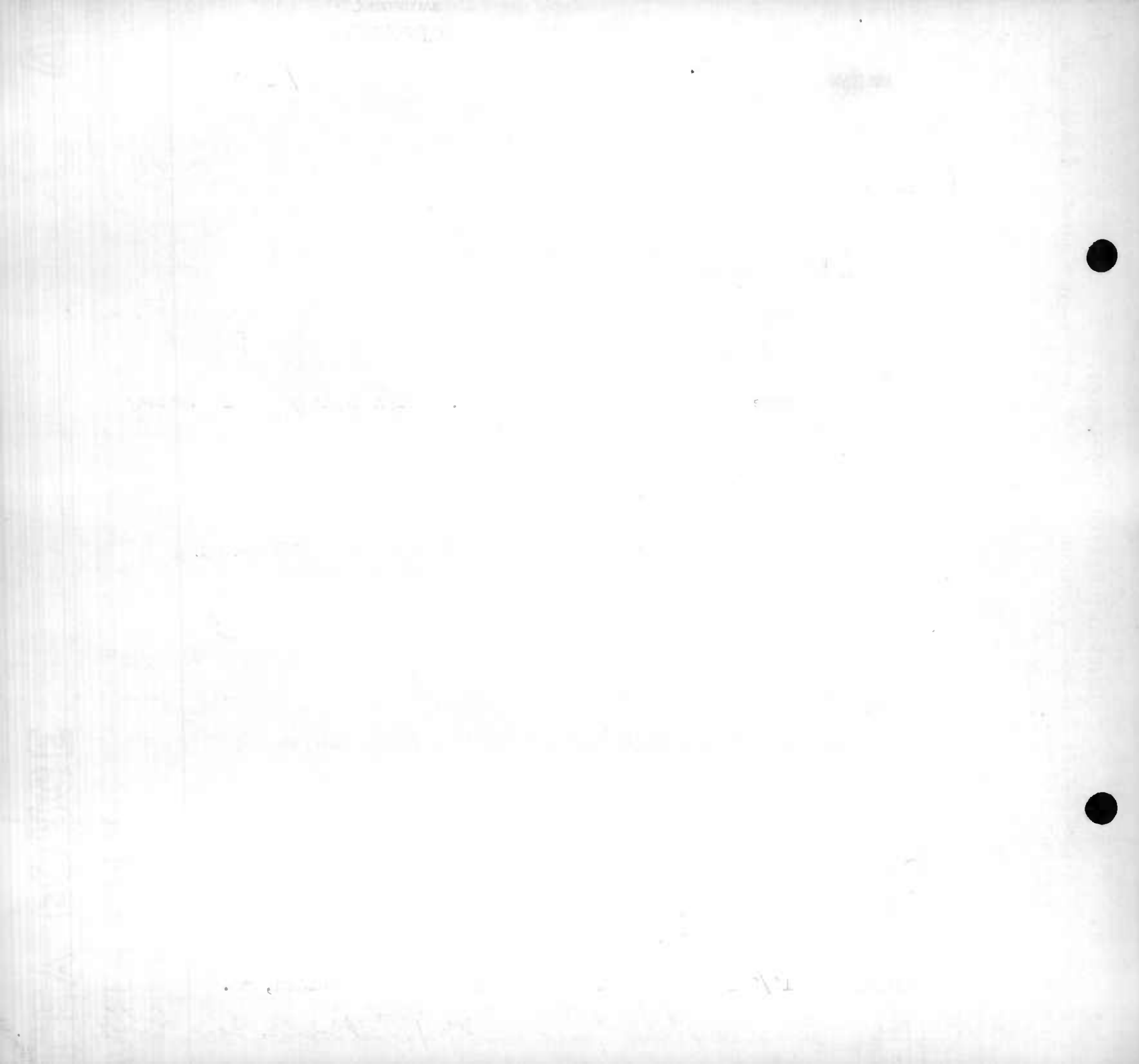
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 12076	
BIRTH NO. 66 12076											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <i>George Miller</i>						2. DATE AND HOUR OF DEATH <i>12/1/66 1:00 P. M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Harford Gardens Nursing Home</i> <i>90</i>						A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co.</i>					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Parkville</i> <i>53-00</i>					
						D. STREET ADDRESS (If rural, give location) <i>2613 Windsor Rd.</i>					
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>9/27/1882</i>		9. AGE (In years last birthday) <i>84</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self Employed</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Leather Goods</i>				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frederick Miller</i>						14. MOTHER'S MAIDEN NAME <i>Bertha ?</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mr. Earl Miller - 2613 Windsor Rd. #34</i>					
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <i>Arteriosclerotic Heart Disease</i> DUE TO (B) _____ DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <i>Several Years</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Benign Prostatic Hypertrophy</i>						Interval between onset and death <i>1 week</i>					
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>November 25 1966</i> to <i>Dec. 1 1966</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>December 1 1966</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.											
23A. SIGNATURE <i>L. M. Zimmerman</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>Dec 1, 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Lou Zimmerman</i>						23D. ADDRESS M.D. <i>3202 Harford Rd.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>12/5/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Western Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 2 1966</i>				25B. NAME OF REGISTRAR <i>Leonard J. Ruck Inc.</i>				25C. FUNERAL DIRECTOR ADDRESS <i>5305 Harford Rd.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 12077	
BIRTH NO. 66 12077		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>CARRIE D. Corbin</u>		2. DATE AND HOUR OF DEATH <u>11-30/1966</u> <u>4:45</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD</u>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>12-02</u>			
				D. STREET ADDRESS (If rural, give location) <u>227 E. UNIVERSITY PARKWAY</u> <u>#12</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>1-25-89</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry D. S. H. Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Reifner</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Mrs. Carolyn Draisay 4410 Eastway</u>			
18. <u>237X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>DECREASED INTRACRANIAL PRESSURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral tumor</u>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>3-11-26-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain Tumor</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-21</u> 19 <u>66</u> to <u>11-30</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-30</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-30-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joel Galbranson</u>				23D. ADDRESS <u>Mercy Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/2/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1966</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Wm. F. Tarkenton Sons</u>		ADDRESS <u>Baltimore, Md. North Ave.</u>	



P-620

66 12078

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12078

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
GEORGE H PARRISH		November 30, 1966 3:50 A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland	
1048 N. Broadway		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 1048 N. Broadway	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	White	Divorced	Sept. 25, 1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Laborer			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Lee Parrish		Alice Spradlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT		ADDRESS	
Pauline Williams		2631 Joppa Terrace	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) Arteriosclerotic Cardiovascular Disease. DUE TO  (B) DUE TO  (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Petty		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED		11/30/66	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		12/3/66	
23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Baltimore		Baltimore	
24A. DATE REC'D BY HEALTH DEPT.		24C. FUNERAL DIRECTOR	
DEC 2 1966		Leonard J. Rick Inc 5305 Harford Rd	

WALLLEY PHOTOGRAPH

RECYCLED PAPER

100%

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12079	
BIRTH NO. 66 12079		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>LINDSAY, REGINA COSTER</b>		2. DATE AND HOUR OF DEATH <b>11/29 1966 1 740 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>95 DELMAR AVENUE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 12, 1902</b>	9. AGE (in years last birthday) <b>64</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Re. Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FRANK S. COSTER</b>		14. MOTHER'S MAIDEN NAME <b>CLARA S. Sweitzer</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-14-1813</b>		17. INFORMANT <b>Richard Fifer</b> ADDRESS <b>95 Delmar Ave Baltimore Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>194X I Melanotic cancer of the Thyroid, generalized</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/25 1966</b> to <b>11/29 1966</b> , that (I) (we) last saw the deceased alive on <b>11/29 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Petursson</b>				23B. DATE SIGNED <b>11/29 '66</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. PETURSSON</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL CALVERT AND 3RD STREETS, BALTIMORE MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/2/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION <b>Baltimore</b>		24E. STATE <b>Maryland</b>		24F. ADDRESS <b>5305 Harford Rd</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 2 1966</b>		25B. NAME OF REGISTRAR <b>Leonard J Ruck Inc.</b>		25C. FUNERAL DIRECTOR <b>5305 Harford Rd</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12080				Baltimore City Health Department CERTIFICATE OF DEATH		Registered No. 66 12080	
1. NAME OF DECEASED (Type or Print) <b>BABY BOY BRYANT</b>				2. DATE AND HOUR OF DEATH <b>NOV. 28, 1966 9:10 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF 46 MARYLAND</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 20-02</b>			
				D. STREET ADDRESS (If rural, give location) <b>2441 LAURETTA Ave</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>11/17/66</b>	9. AGE (In years last birthday) <b>10 days</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel</b>				14. MOTHER'S MAIDEN NAME <b>MAggie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <b>766.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>SEPTICEMIA</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>NOV. 17</b> 19 <b>66</b> to <b>NOV. 28</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>NOV. 28</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>79 Herama</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/28/66</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. <b>LUTHERAN HOSP. OF MD.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>12-1-66</b>		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE RECEIVED		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR		ADDRESS	

LIBRARY OF THE

UNIVERSITY OF

CHICAGO

SEPTEMBER

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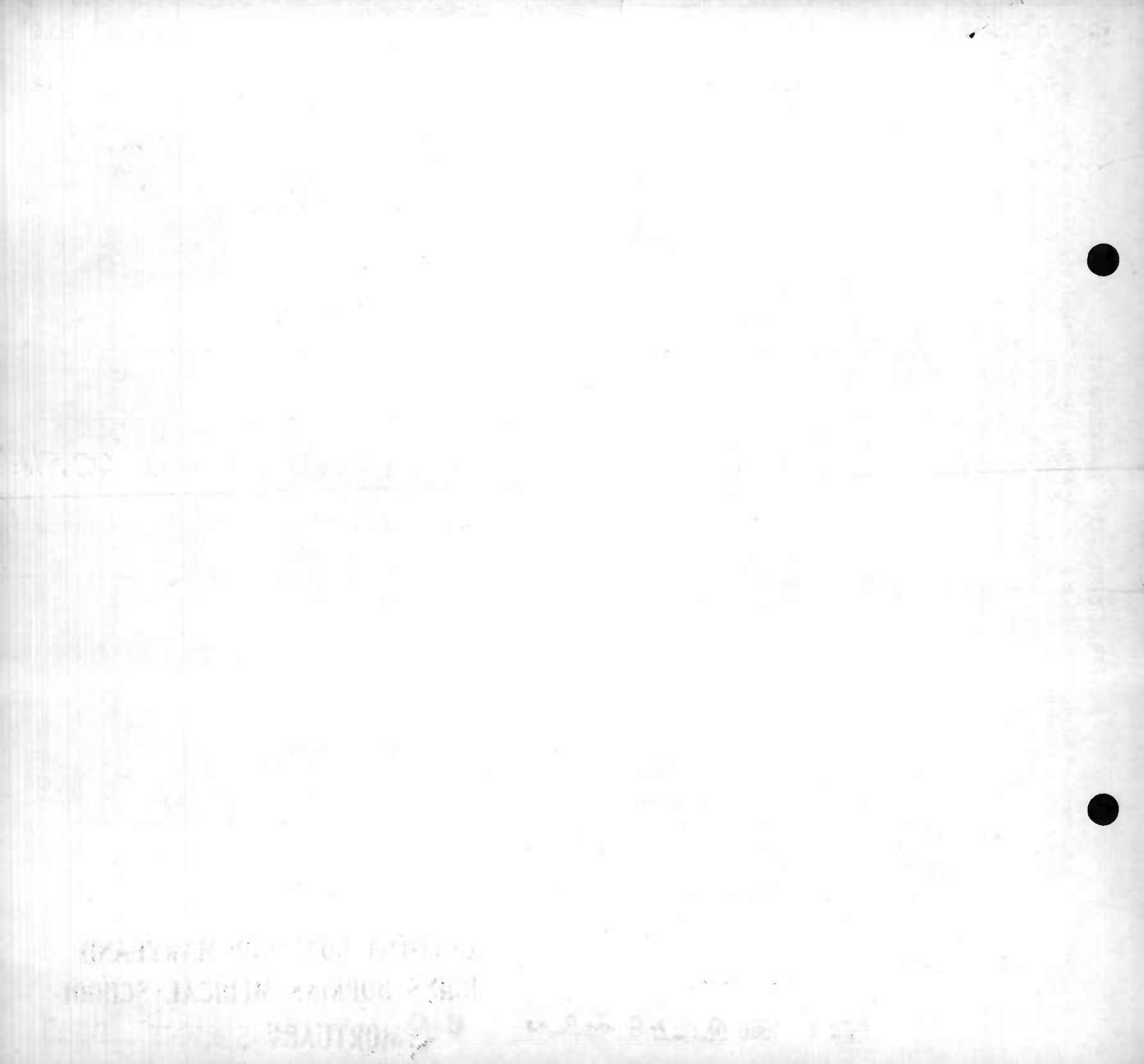
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No.	
CERTIFICATE OF DEATH										66 12081 ✓	
BIRTH NO. 66-25723		66 12081									
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>BURTON, Baby Girl</b>				2. DATE AND HOUR OF DEATH <b>11/30/66 1:25 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 28-03</b>				D. STREET ADDRESS (If rural, give location) <b>2217 TUCKER Lane</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>-</b>		8. DATE OF BIRTH <b>11/29/66</b>		9. AGE (In years lost birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Wm. J. Burton, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Maribeth ENZIAN</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. <b>723.5 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hyaline Membrane Disease 22.5 hrs</b> <b>Prematurity</b>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO				(B) DUE TO			
				(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (1) (this hospital) attended the deceased from <b>11/29 19 66</b> to <b>11/30 19 66</b> , that (1) (we) last saw the deceased alive on <b>11/30 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Sanford Levin</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>11/30/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>SANFORD LEVIN</b>				23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND</b> <b>JOHNS HOPKINS MEDICAL SCHOOL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-2-66</b>		24C. NAME OF CEMETERY or CREMATOR		24D. ADDRESS (State)					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS							
<b>DEC 5 1966</b>		<b>John E. Johnson</b>		<b>000 MORTUARY SERVICE SCUR</b>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

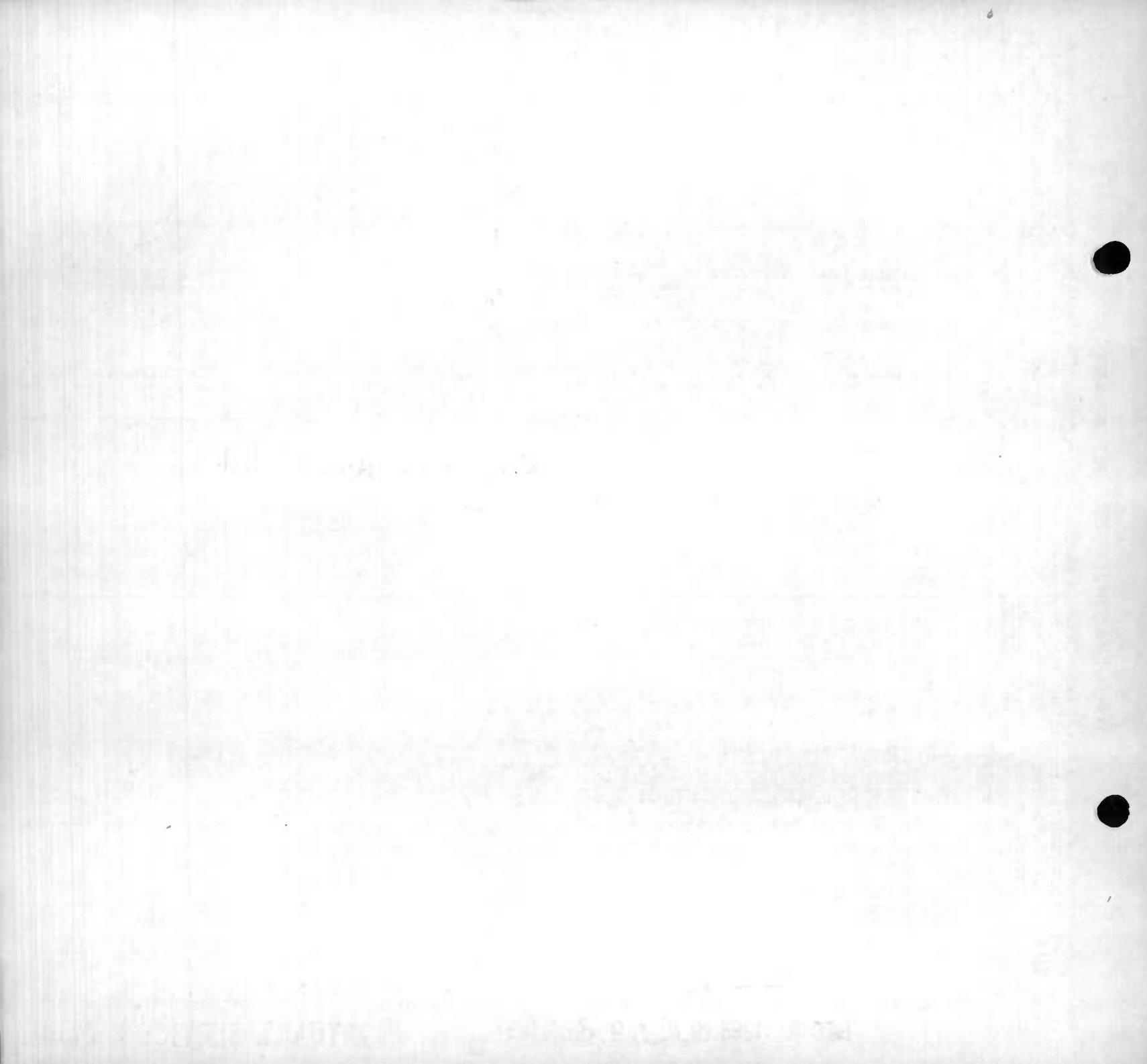
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. <u>46-19561 66 12082</u>					CERTIFICATE OF DEATH					Registered No. <u>66 12082</u>									
1. NAME OF DECEASED (Type or Print) <u>BABY BOY HACKNEY</u>					2. DATE AND HOUR OF DEATH <u>8-9-66</u> <u>12:10A</u> M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL of BALTIMORE, Inc.</u> <u>42</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Balt. Co</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>PIKESVILLE</u> D. STREET ADDRESS (If rural, give location) <u>31 WOODED WAY</u>														
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>8-8-66</u>		9. AGE (In years last birthday) <u>NEW BORN</u>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>									
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME <u>CHARLES L. HACKNEY</u>					14. MOTHER'S MAIDEN NAME <u>CHRISTINE MULCHI</u>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS									
18. <u>7-9-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Asphyxia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Conjunctal hemorrhage</u>										CAUSE OF DEATH (A) <u>Asphyxia</u> (B) <u>Asphyxia</u> (C) <u>Conjunctal hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>NO</u>									
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>Stanley Goldsmith</u> M.D.					23B. DATE SIGNED <u>8/26/66</u>					23C. PHYSICIAN'S NAME (Type) <u>Stanley Goldsmith</u> M.D.									
23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>					24A. BURIAL, CREMATION, REMOVAL (Specify) <u>12-2-66</u>					24B. DATE									
24C. NAME of CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>					24D. LOCATION (City, town, or county) (State) <u>MORTUARY SERVICE</u>					25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1966</u>									
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>					25C. FUNERAL DIRECTOR ADDRESS <u>00</u>					25D. MORTUARY SERVICE <u>BOHD</u>									



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

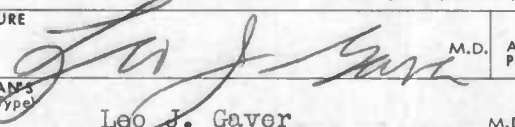
BIRTH NO. <u>66 34506 66 12083</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 12083 4</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LEMOINE Baby Boy</u>		2. DATE AND HOUR OF DEATH <u>11/14 66 17<sup>10</sup> A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 53-00</u> D. STREET ADDRESS (If rural, give location) <u>2762 Yarnell Rd.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Newborn</u>	8. DATE OF BIRTH <u>11/14/66</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>3 20</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Gilbert Lemoine</u>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Hospital Records</u>		ADDRESS
18. <u>773.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive Heart Failure</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/14 3:30 AM 19 66</u> to <u>11/14 4:10 PM 19 66</u> , that (I) (we) last saw the deceased alive on <u>11/14 19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE <u>Francis Harley</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/14</u>	
23C. PHYSICIAN'S NAME (Type) <u>HARLEY</u>		23D. ADDRESS <u>Sinai Hospital, Baltimore, Maryland</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>12-2-66</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION		24E. CITY, TOWN, AND COUNTY		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>DEC 5 1966</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCND</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12084					CERTIFICATE OF DEATH			Registered No. 66 12084	
1. NAME OF DECEASED (Type or Print) <b>ANNE VanHOLLEN</b>					2. DATE AND HOUR OF DEATH <b>DECEMBER 1, 1966</b>   <b>9:15 A.</b> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Hood Conv. Home</b> <b>90</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balts. Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Catonsville</b> D. STREET ADDRESS (If rural, give location) <b>53-00</b> <b>3 Beaumont Avenue</b>				
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>Oct 29, 1879</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Patrick Flanagan</b>					14. MOTHER'S MAIDEN NAME <b>Mary Banahan</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>212-01-5427D</b>		17. INFORMANT <b>Mrs Mary Anne Hook</b>				
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-vascular Disease</b>			CAUSE OF DEATH (A) <b>Arteriosclerotic Cardio-vascular Disease</b> DUE TO (B) _____ DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from <b>November 19 49</b> to <b>Nov. 19 66</b> , that (I) <b>yes</b> lost saw the deceased alive on <b>Nov. 22 19 66</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>we</b> (did) <b>not</b> view the body after death.									
23A. SIGNATURE  M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23C. PHYSICIAN'S NAME (Type) <b>Leo J. Gaver</b>						23B. DATE SIGNED <b>12/2/66</b>			
23D. ADDRESS <b>1 Mallow Hill Ave., Baltimore, Md.</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec 3, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>Leo J. Gaver</b>		25C. FUNERAL DIRECTOR <b>STERLING FUNERAL ESTATE</b>					
				ADDRESS <b>736 Edm. Av. Catonsville, Md.</b>					

Dr. J. H. H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No. 66 12085	
BIRTH NO. 66 12085		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>John Patrick Mooney SR.</b>		2. DATE AND HOUR OF DEATH <b>1 Dec 1966 11<sup>10</sup> P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE Co</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ESSEX</b> <b>53-00</b> D. STREET ADDRESS (If rural, give location) <b>103 BENNETT RD #21221</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3-24-02</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANK MOONEY</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET MURPHY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>213-32-2018</b>		17. INFORMANT <b>BALTIMORE, MD. 21224</b> <b>RECORDS-BCH-4940 EASTERN AVENUE,</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple CVA's</b> <b>Cerebral Vascular Dis.</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Probable Ca of Esophagus</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>29 Nov 1966</b> to <b>1 Dec 1966</b> , that (we) last saw the deceased alive on <b>1 Dec 1966</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dudley A. Raine</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1 Dec 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. DUDLEY A. RAINE, JR.</b>		23D. ADDRESS <b>BCH-4940 EASTERN AVENUE - 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>12/5/66</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md</b>	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR <b>W. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>W. E. Taylor</b>		ADDRESS <b>300 more</b>

11-10-9

1 Dec 1966

John Patrick McManus

Multiple CVM's  
Cerebral Vascular Dis.

No  
Multiple C of Esophagus

1 Dec 1966

1 Dec 1966

Robert McManus

1 Dec 1966

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12086		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12086	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Albert M. Cashour			2. DATE AND HOUR OF DEATH Nov. 30, 1966 6:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 714 Dorchester Rd.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 714 Dorchester Rd.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	B. DATE OF BIRTH Aug. 7, 1909	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Manager		10B. KIND OF BUSINESS OR INDUSTRY Transit- Storage Co.	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Clarence W. Cashour			14. MOTHER'S MAIDEN NAME Catharine G. Eckenrode		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-4041	17. INFORMANT Balto. Md. Mrs. Catherine L. Cashour 714 Dorchester Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Circumstances (B) Adenocarcinoma of sigmoid (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 6 months		
19A. DATE OF OPERATION April 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of sigmoid	20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 1966 to 11/30 1966, that (I) (we) last saw the deceased alive on 11/30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DAMIAN PALAGIA M.D.			23B. DATE SIGNED 12/1/66		23C. PHYSICIAN'S NAME (Type) DAMIAN PALAGIA M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 3, 1966	24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1966		25B. NAME OF REGISTRAR R. B. E. Talbot		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.	

DAVID & BROS  
HARRISON TOLSON

X

330 Hudson Street  
1911

11/30

april

cc

11/30

april 11/30

1911  
1911

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12087		BALTIMORE CITY HEALTH DEPARTMENT		66 12087		Registered No. <del>66 12087</del>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Rice, Lillian L. Cornish</u>				2. DATE AND HOUR OF DEATH <u>11/30/66</u> <u>5:17 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Md.</u>		B. COUNTY <u>Baltimore</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>1714 Darley Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>8/31/05</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Cornish</u>				14. MOTHER'S MAIDEN NAME <u>Jane Collings</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Luther Rice</u>		ADDRESS <u>1714 Darley Ave</u>	
18. <u>199.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma</u>				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Peter Rosen</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/30/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Peter Rosen</u>				23D. ADDRESS M.D. <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/5/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel City, Md</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Edwards</u>		25C. FUNERAL DIRECTOR <u>Wm. V. March</u>		ADDRESS <u>928 E NORTH AVE</u>	

22 OM  
3701111 47  
Suff No 1346. 4151  
12 501519

070200



66 12088

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12088

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MELVIN

E.

WISNOM

2. DATE AND HOUR PRONOUNCED DEAD

December 2, 1966

5:10 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2102 E. Baltimore Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2102 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 29, 1908

9. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Anchor Motor Freight

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wilmer WisNom

14. MOTHER'S MAIDEN NAME

Loura Hines

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW2 1942- 1944

16. SOCIAL  
SECURITY NO.

217-07-4697

17. INFORMANT

Frances Wisnom

ADDRESS

2102 e. Baltimore St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Notural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
12/2/6623A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-5-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

1217 St. Paul St.

WM. Cook Brooks Inc.

Baltimore, Maryland

VALLEY FORDS

1  
E-350

66 12089

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12089

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JESSE

EATON

2. DATE AND HOUR PRONOUNCED DEAD

12-3-66

8:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2601 Greenmount

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

9-04

D. STREET ADDRESS (If rural, give location)

2601 Greenmount

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Unknown

8. DATE OF BIRTH

1/6/04

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Florida

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benjamin H. Eaton

14. MOTHER'S MAIDEN NAME

Katie Jameson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

X New Bern, N. Carolina

Willis &amp; Ballard F. H. 226 Broad St.

18.

420.0 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-3-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/6/66

23C. NAME of CEMETERY or CREMATORY

New Dern Mem. Cemetery

23D. LOCATION

(City, town, or county)

(State)

New Bern, N. Carolina

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

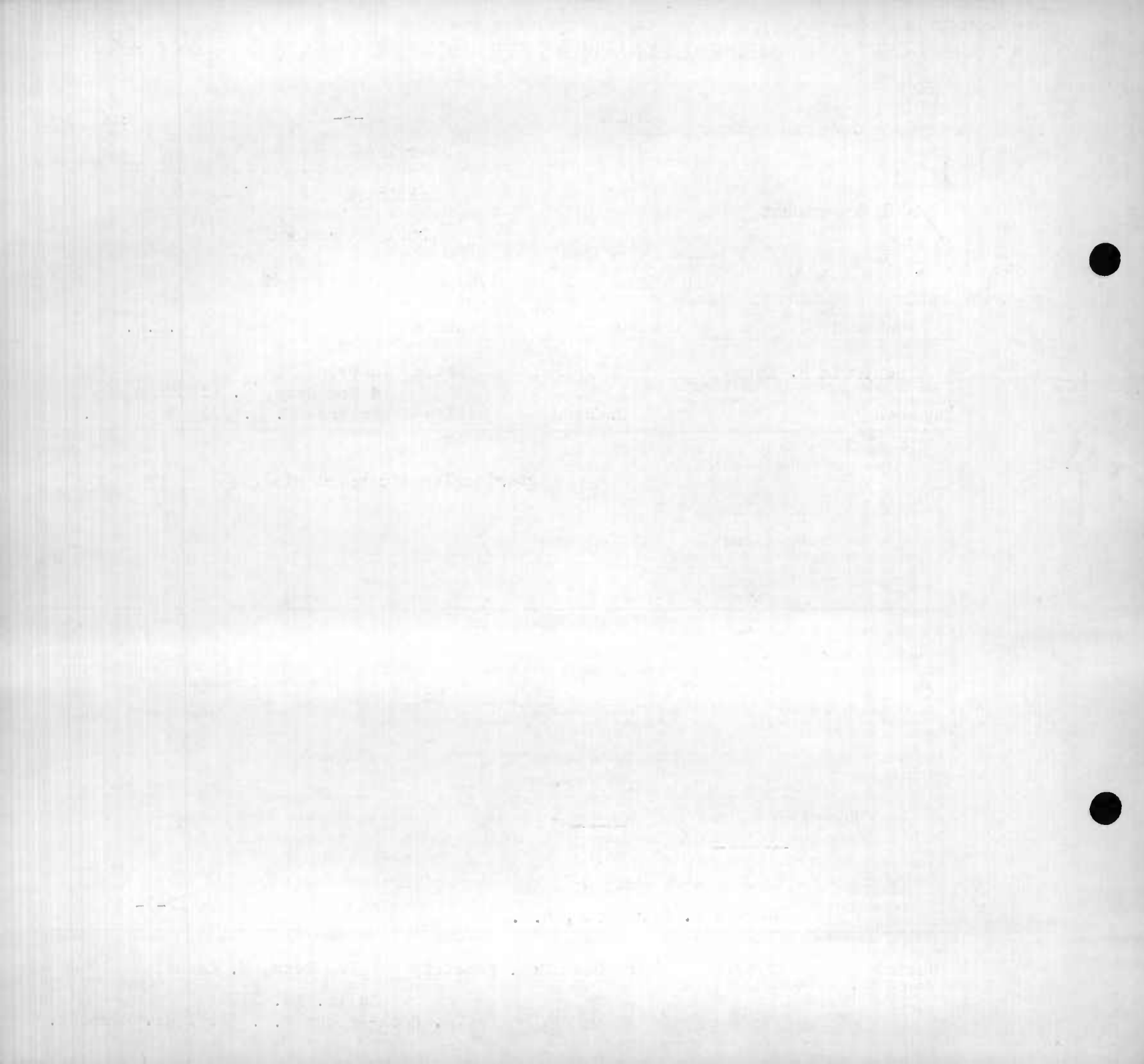
24C. FUNERAL DIRECTOR

ADDRESS

DEC 5 1966

Robert E. Taylor, M.D.

Balto. Md. 21202  
Wm. Cook-Brooks F.H. 1217 St. Paul St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12090		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12090	
M.E. CASE NO.		CERTIFICATE OF DEATH		P.M.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
E. Hope Malin		Nov. 27, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY Kent Co.			
Gould Convalesarium 6116 Belair Road Baltimore, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		64-00	
		D. STREET ADDRESS (If rural, give location)			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
female	white	Widowed	11/10/1879	87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife & Retired teacher				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Samuel Wallis		Mary Catherine Lynch		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		217 16 9157		Mrs. Ruth Bullock 3332 Wilobough Rd. Balto. Md.	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		one week	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) Arteriosclerotic Cardiovascular Disease		years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 19 65 to Nov 19 66, that (I) last saw the deceased alive on 11-21-19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Joseph F. Palmisano		11/28/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Joseph F. Palmisano		6608 Loch Raven Blvd. Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/30/66		Chester Cemetery	
				Chestertown, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 5 1966		J. E. F. F. F.		J. E. F. F. F. Chestertown, Md.	

General

Director

No

12

year

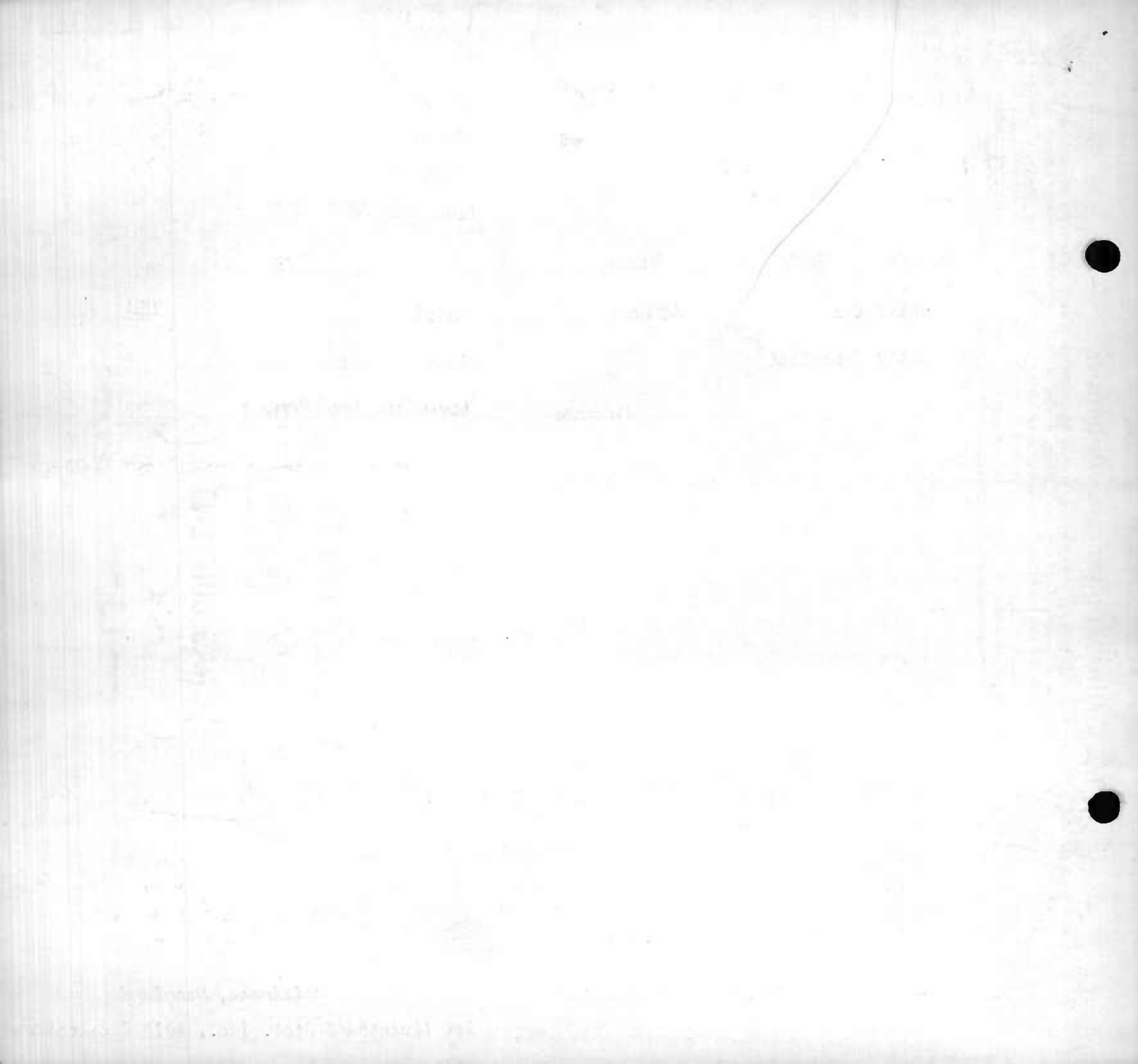
W. J. C. C.

W. J. C. C.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12091</u>	
BIRTH NO. <u>66 12091</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Sarah Blacker</u>		2. DATE AND HOUR OF DEATH <u>November 30 1966 7<sup>35</sup> P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LEVINDALE, HEBREW HOME AND INFIRMARY -</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>Levindale Aged Home</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>83</u>	9. AGE (In years lost birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry Rosenthal</u>		14. MOTHER'S MAIDEN NAME <u>Lena ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Levindale Aged Home</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>ASCVD</u>		CAUSE OF DEATH (A) <u>myocardial infarction</u> (B) <u>ASCVD</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Bronchopneumonia</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>nr</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20 1953</u> to <u>Nov. 30 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 30 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Ruth Willner</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Nov. 30. 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ruth Willner</u>		23D. ADDRESS <u>LEVINDALE, HEBREW HOME AND INFIRMARY -</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/2/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oheb Shalom</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1966</u>			
25B. NAME OF REGISTRAR <u>Robert J. Feltner</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12092	
BIRTH NO. 66 12092		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>LOOBAN, WILLIAM</b>		2. DATE AND HOUR OF DEATH <b>12/2/66 7:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b>		A. STATE <b>MD</b> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 27-20</b>			
		D. STREET ADDRESS (If rural, give location) <b>3817 - GLEN AVE</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>9/15/97</b>	9. AGE (In years lost birthday) <b>69</b>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Burlap Bags</b>		11. BIRTHPLACE (State or foreign country) <b>LATVIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Chaim Arye Looban</b>		14. MOTHER'S MAIDEN NAME <b>Rachael ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W. 1 Army</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT ADDRESS <b>Mrs. Blanche Looban, 3817 Glen Avenue</b>	
18. <b>331X1</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <b>C.V.A.</b>		<b>3 days</b>	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) <b>HYPERTENSION</b>		<b>? years</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>11/30 1966</b> to <b>12/2 1966</b> , that (I) (we) last saw the deceased alive on <b>12/2 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Stephen Gordon</b>				23B. DATE SIGNED <b>12-2-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stephen Gordon</b>				23D. ADDRESS <b>Sinai Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/2/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Shearith Israel</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>ALBERT E. FULMER</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-16 BIRTH NO. 66 12093		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 12093	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>ANNA SILVERMAN</i>		
2. DATE AND HOUR OF DEATH <i>12/1/66 3:05 P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>SINAI HOSP. OF BALT., INC.</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>		
D. STREET ADDRESS (If rural, give location) <i>5426 GIST AVE</i>					
5. SEX <i>F</i>	6. RACE <i>CAU</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>12/17/80</i>	9. AGE (In years lost birth) <i>85</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (State or foreign country) <i>LITHUANIA</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>Adolph Sachs</i>			14. MOTHER'S MAIDEN NAME <i>Rebecca ?</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Mrs. Bessie Snyder, 5426 Gist Avenue #15</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CARDIAC ARHRHYTHMIA</i> DUE TO <i>MYOCARDIAL INFARCTION</i> DUE TO <i>PULMONARY EDEMA</i>			INTERVAL BETWEEN ONSET AND DEATH <i>20 minutes</i> <i>5 days</i> <i>5 days</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <i>5</i> (this hospital) attended the deceased from <i>11/27</i> 19 <i>66</i> to <i>12/1</i> 19 <i>66</i> that (I) <i>did</i> last saw the deceased alive on <i>12/1</i> 19 <i>66</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>did</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. Brett Lazar</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <i>12/1/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. BRETT LAZAR</i>			23D. ADDRESS <i>Sinai Hosp. of Baltimore, Inc.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12/4/66</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Beth Hamedrosh Hagadol</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 5 1966</i>		25B. NAME OF REGISTRAR <i>R. E. E. E.</i>	25C. FUNERAL DIRECTOR ADDRESS <i>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12094</u>	
630 BIRTH NO.		66 12094		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Barney Hart</u>		2. DATE AND HOUR OF DEATH <u>December 2nd 1966 6:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Sinai Hospital of Baltimore</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
42		D. STREET ADDRESS (If rural, give location) <u>3006 W. Garrison Ave</u>		27-17	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10/11/07</u>	9. AGE (In years lost birthday) <u>59</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>		11. BIRTHPLACE (State or foreign country) <u>Siberia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Hart</u>		14. MOTHER'S MAIDEN NAME <u>Dora ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Libby Hart, 3006 W. Garrison Avenue #15</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>527.11x260X</u>		CAUSE OF DEATH (A) <u>Pulmonary Emphysema</u> DUE TO (B) <u>ASCVD</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus</u>		<u>Unknown</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 2nd 1966</u> to <u>Same</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 2nd 1966 6:30 A.M.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Wm. Cieplinski</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/1/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Wm. Cieplinski</u>		23D. ADDRESS <u>Sinai Hospital Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/4/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Har Zion Tifereth Israel</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Finkelman</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>			

2

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

Released by M.E. J. J. J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12095		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12095	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JESSIE M. SMITH		2. DATE AND HOUR OF DEATH 12/1/66 3 25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital		A. STATE Md., 21211			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-15			
		D. STREET ADDRESS (If rural, give location) 426 Grand View Avenue			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 8/13/98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY John Duer & Co.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Henry Smith		14. MOTHER'S MAIDEN NAME Belle Thompson		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-8874		17. INFORMANT ADDRESS Viola E. Christ, cousin, 3501 Elmora Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO EPI DURAL HEMATOMA (B) DUE TO FRACTURED SKULL (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 Days 6 Days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) APPROVAL BY M.E. 11/25/66		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4426 GRANDVIEW AVE #11	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELT DIZZY - HYPOGLYCEMIA Fall to floor	
22. I certify that (I) (this hospital) attended the deceased from 11/25 to 12/1 and that (I) (we) last saw the deceased alive on 12/1 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Schell		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/1/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/66		24C. NAME OF CEMETERY or CREMATORY Zion Evang. Luth. Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
66 12096		66 12096		66 12096	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				Mrs Edith P. Stringer (Stringer)	
2. DATE AND HOUR OF DEATH		12-7-66		1:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland Baltimore Co		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Church Home and Hospital		Dundalk 21222		53-00	
D. STREET ADDRESS (If rural, give location)		34 Shipway			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	Married	9/16/1890	76	U.S.A.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Canada		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Matthew Elliott		Melissa File			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		none		David E. Stringer, same as #4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Myocardial infarction		for few min.	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Pulm. Embolism			
		(B) DUE TO			
		R) Middle lobe pneumonia for 1 day			
		(C) Phlebotrombosis left leg			
II		Severe Diverticulosis of sigmoid colon			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Adenocarcinoma of ut.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11/16, 11/25		Diverticulosis sigmoid Adeno CA - uterus		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		11/15/66		19 to 12/3/66 19	
that (I) (we) last saw the deceased alive on		12/3/66		19 and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
D. V. Santor				12-3-66	
23C. PHYSICIAN'S NAME (Type)		M.D.		23D. ADDRESS	
Reddy				Church Home & Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/5/66		Meadowridge Memorial	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Dorsey, Maryland		DEC 5 1966		Walter Brooks Bradley, Inc., Dundalk	
24G. FUNERAL DIRECTOR ADDRESS		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	
				Walter Brooks Bradley, Inc., Dundalk	

YES

12/1/11

12/1/11

12/1/11

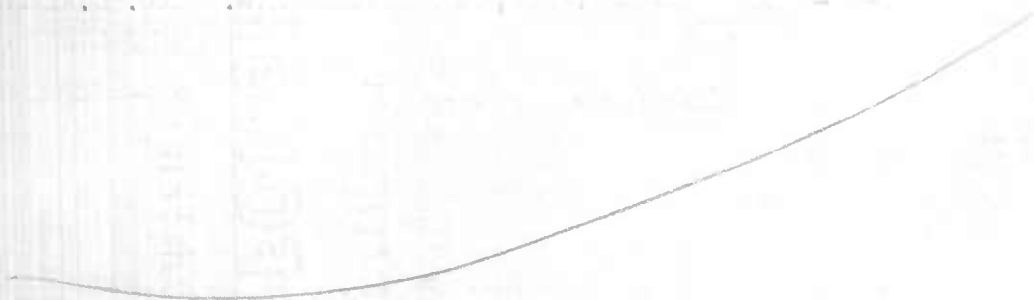
Heidi V. F.

47-98-83  
NW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 12097		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12097	
BIRTH NO.		M.E. CASE NO. Suchanek, W		1. NAME OF DECEASED (Type or Print) Suchanek, Walter	
2. DATE AND HOUR OF DEATH 11/30/66 1:25 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-44		D. STREET ADDRESS (If rural, give location) 109 N. HIGHLAND AVENUE - 21224	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 6/30/10	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Fitter		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWARD SUCHANEK		14. MOTHER'S MAIDEN NAME MARGARET DOYLE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-07-1522		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave. Balto. Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Cardiac arrest DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ca of esophagus		19A. DATE OF OPERATION 3 11/23		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of esophagus	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (H) (this hospital) attended the deceased from 10/25/1966 to 11/30/1966, that (H) (we) last saw the deceased alive on 11/30/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Carl Wintersstein		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/30/66	
23C. PHYSICIAN'S NAME (Type) Carl Wintersstein		23D. ADDRESS 4940 Eastern Avenue, Balto. Md. 21224		M.D. Balto. City Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-3-66		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. (State)		25A. DATE REC'D BY HEALTH DEPT. DEC 5 1966	
25B. NAME OF REGISTRAR R. E. F. J. J. J.		25C. FUNERAL DIRECTOR John C. Miller, Inc.		25D. ADDRESS 415 Belair Rs. - 21206	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 12098		CERTIFICATE OF DEATH		Registered No. 66 12098	
1. NAME OF DECEASED (Type or Print) <b>Irving White</b>				2. DATE AND HOUR OF DEATH <b>December 2, 1966</b> <b>4:50 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1701 Linden Avenue</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>3-21-09</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Randolph White</b>				14. MOTHER'S MAIDEN NAME <b>Emma Cousins</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Violet White</b> <b>1701 Linden Avenue</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized metastasis of liposarcoma including heart, lung, kidney, pancreas and skin ducts retroperitoneal liposarcoma</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Pulmonary congestion and hemorrhage of both lower lobes.</b>				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>November 23, 1966</b> to <b>December 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 2, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>December 2, 1966</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. E. E. Taylor</b>				23D. ADDRESS M.D. <b>1514 Division Street</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-7-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat'l. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>George Nelson</b>		ADDRESS <b>1348 N. Calhoun St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12099		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12099	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Richard T. Green		2. DATE AND HOUR OF DEATH 12-2-66 5:35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28-03			
		D. STREET ADDRESS (If rural, give location) 4103 Westchester Rd.			
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-13-09	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Truck Driver				Maryland	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME Richard Green		14. MOTHER'S MAIDEN NAME Lula		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 212102255		17. INFORMANT Dorothy Green		ADDRESS 4103 Westchester Road	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Central Compression & Edema			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Subarachnoid hemorrhage			
		(C) Central Anomalous			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 11-21-66 to 12-2-66, that (we) lost saw the deceased alive on 12-2-66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Hameroff		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-2-66	
23C. PHYSICIAN'S NAME (Type) Stephen Hameroff		23D. ADDRESS 1213 Light Street.			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 12-6-66		24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.	
				24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR George C. Nelson		25C. FUNERAL DIRECTOR ADDRESS 1348 Calhoun Street	

Intel Corporation - Future  
Technical and Financial  
Control Advantage

W. H. H. H.



S-300

66 12100

BALTIMORE CITY HEALTH DEPARTMENT

66 12100

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE

SCOTT

2. DATE AND HOUR PRONOUNCED DEAD

December 1, 1966

4:35 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 641 North Carey Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

641 North Carey Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

7-15-92

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

220-02-7897

17. INFORMANT

ADDRESS

Warren Baynor 1028 Whatcoat Street

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive  
DUE TO Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-5-66

23C. NAME of CEMETERY or CREMATORY

Balto. Nat'l. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 5 1966

George Kelson 1348 N. Calhoun St.

WILLIAM BODDIE

2150 WALKER STREET

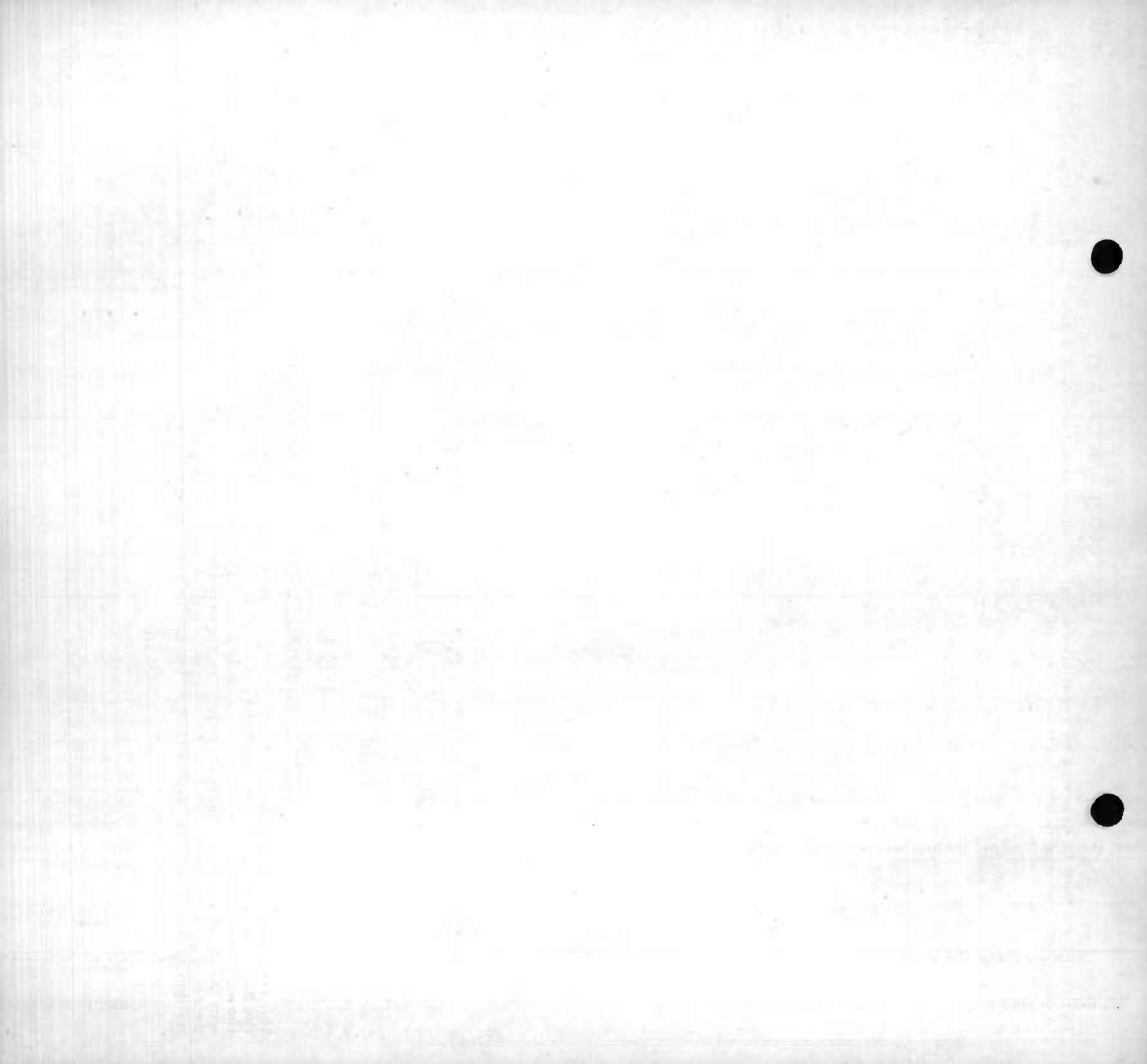
W. B. BODDIE

✓

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12101				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12101	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mary Shelton</i>				2. DATE AND HOUR OF DEATH <i>12-1-66 7:15 A.M.</i>			
3. PLACE OF DEATH IN <i>BALTIMORE, MARYLAND</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>25-32</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hosp.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21225</i>			
				D. STREET ADDRESS (If rural, give location) <i>2909 Denham Circle</i>			
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>10-1-97</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <i>Hager, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Sarah Allen 2909 Denham Circle</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>4-22-11</i>				CAUSE OF DEATH (A) DUE TO <i>CVA</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>ASCVD</i>				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CVA</i>				(C)			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <i>11-9</i> 19 <i>66</i> to <i>12-1</i> 19 <i>66</i> , that (we) last saw the deceased alive on <i>12-1</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Rufus Abouy</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-1-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Rufus Abouy</i> M.D.				23D. ADDRESS <i>1213 Light St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-5-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Church Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Warsaw, Virginia</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 5 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>George D. Kelson</i>		ADDRESS <i>1318 N. Calhoun St.</i>	



66 12102

BALTIMORE CITY HEALTH DEPARTMENT

66 12102

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN

TYSON

2. DATE AND HOUR PRONOUNCED DEAD

December 1, 1966

8:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2029 Brunt Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

2-14-97

9. AGE (In years  
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

241-14-1834

17. INFORMANT

ADDRESS

Elver Ingram 2029 Brunt Street

18.

443X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive  
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/2/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-6-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

George Nelson 1348 N. Calhoun St.

VALLEY FORGE

SEPTEMBER 1776

PAID

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12103</u>	
BIRTH NO. <u>66 12103</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>CALDWELL MABEL T.</u>		2. DATE AND HOUR OF DEATH <u>12/2/66 11:55 PM</u>	
3. PLACE OF DEATH <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>BALTIMORE MD.</u> B. COUNTY <u>21216</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF MARYLAND</u> <u>46</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>1257 N. BENTLEY ST. 16-05</u>			
D. STREET ADDRESS (If rural, give location)					
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> (Specify)	8. DATE OF BIRTH <u>1/13/95</u>	9. AGE (In years lost birthday) <u>71</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Edward Caldwell</u>			14. MOTHER'S MAIDEN NAME <u>Mary Frezz</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Willie Caldwell</u> ADDRESS <u>1257 N. Bentley St.</u>	
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CARDIAC ARREST</u> DUE TO (B) <u>CONGESTIVE HEART FAILURE</u> DUE TO (C) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>DEC 19 66</u> to <u>DEC 2 19 66</u> , that (I) (we) last saw the deceased alive on <u>DEC 2 19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Young Kil Kim</u> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>YOUNG KIL KIM</u> M.D.				23D. ADDRESS <u>LUTHERAN HOSPITAL OF MARYLAND</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/5/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>mt Auburn Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>DEC 5 1966</u>		25C. FUNERAL DIRECTOR <u>1379A Calver St</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

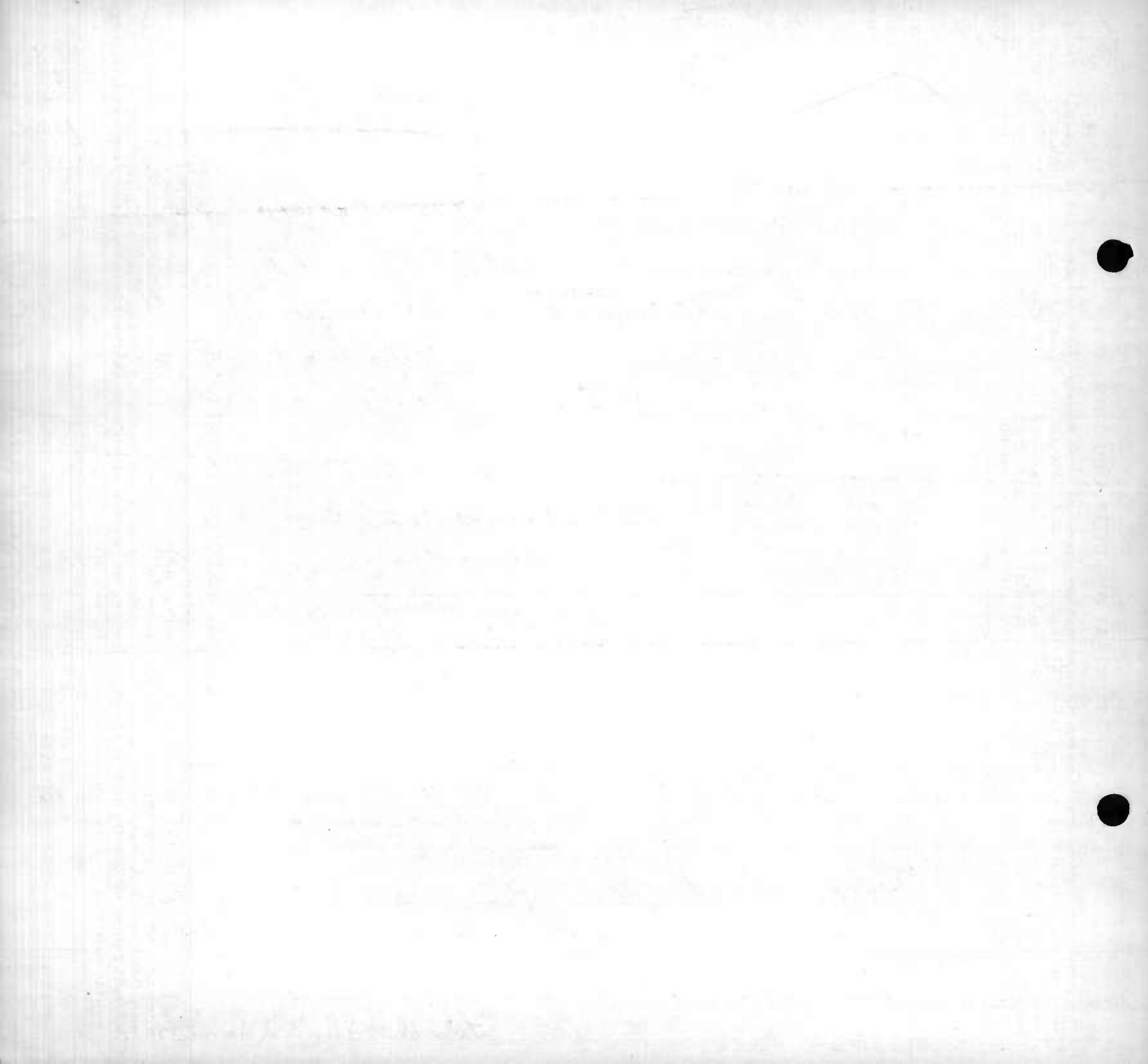
BIRTH NO. <span style="font-size: 1.5em;">66 12104</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">66 12104</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">SHANAMAN, JOHN R.</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">11/30/66</span> <span style="font-size: 1.2em;">12:50 P.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">SINAI HOSPITAL OF BALTIMORE, INC.</span> <span style="font-size: 1.2em;">42</span>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE Co.</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">53-00</span> <span style="font-size: 1.2em;">8117 LOCH RAVEN BLVD. #4</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10/17/93</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">73</span>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Consolidated Delivery</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Delivery</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MD.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">William Shanaman</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Elizabeth Alexander</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-09-6862A</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs Marie Leach 8117 Loch Raven Blvd. 4</span>	
18. <span style="font-size: 1.5em;">260X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">CHF E Pulmonary edema</span>			INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">5 days</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.5em;">ASCVD</span>			(B) DUE TO <span style="font-size: 1.5em;">years</span>		
(C) <span style="font-size: 1.5em;">diabetes mellitis</span>			<span style="font-size: 1.5em;">years</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <span style="font-size: 1.2em;">11/25/1966</span> to <span style="font-size: 1.2em;">11/30/1966</span> that (I) <u>we</u> last saw the deceased alive on <span style="font-size: 1.2em;">11/30/1966</span> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Hyman Greenfield</span> M.O.				23B. DATE SIGNED <span style="font-size: 1.2em;">11/30/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">HYMAN GREENFIELD M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSPITAL</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12-3-1966</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Parkwood Cemetery</span>	
24D. LOCATION (City, town, or county) <span style="font-size: 1.2em;">Baltimore, Md.</span>		24E. STATE <span style="font-size: 1.2em;">Md.</span>		24F. ADDRESS <span style="font-size: 1.2em;">(36)</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 5 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Labahn Funeral Home 2401 Balduin Road</span>	

11/11/11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 12105		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12105	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				(Type or Print) <u>John ALLAN FERDMAN</u>	
2. DATE AND HOUR OF DEATH		11-29-66 4:36 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)		<u>4725 Hillwig Rd. MARYLAND</u>			
<u>UNIVERSITY HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
<u>38 BALTIMORE; MD.</u>		<u>BALTIMORE 21206-26-01</u>			
D. STREET ADDRESS (If rural, give location)		<u>4725 Hillwig Rd.</u>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
<u>M</u>	<u>W.</u>	<u>M.</u>	<u>10-11-89</u>	<u>77</u>	<u>77</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>RETIRED</u>		<u>RR. Engineer</u>		<u>MARYLAND.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
<u>U.S.</u>		<u>WILBUR FERDMAN</u>			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
<u>VIRGINIA A ROOSE</u>		<u>UNKNOWN.</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
<u>717-07-8672A</u>		<u>CHART. -</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES		(A) <u>UREMIA AND ELECTROLYTE IMBALANCE.</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>METASTATIC CARCINOMA.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <u>ADENO CARCINOMA OF PROSTATE.</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>11-11-66</u>		<u>URINARY OBSTRUCTION</u>		<u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<u>NO.</u>		<u>NO.</u>		<u>NO.</u>	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
<u>NO.</u>		<u>While At Work</u>		<u>Not While At Work</u>	
22. I certify that (this hospital) attended the deceased from <u>11-9-1966</u> to <u>11-29-1966</u> , and that (we) lost saw the deceased alive on <u>11-29-1966</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
<u>Robert L. Doyle</u>		<u>11-29-66</u>		<u>ROBERT L. DOYLE</u>	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)			
<u>UNIVERSITY HOSPITAL</u>		<u>Burial</u>			
24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>12-2-1966</u>		<u>Parkwood Cemetery</u>		<u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>DEC 5 1966</u>		<u>John J. Doyle</u>		<u>2750 Belair Road</u>	



66 12106

BALTIMORE CITY HEALTH DEPARTMENT

66 12106

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN

MEYER

2. DATE AND HOUR PRONOUNCED DEAD

December 1, 1966

11:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

A.A. Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

110 Camrose Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Apr 13, 1888

9. AGE (In years  
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Ret

10B. KIND OF BUSINESS OR INDUSTRY

Shell Oil

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick Myers

14. MOTHER'S MAIDEN NAME

Sophia Himmers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Family

Same

18. CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Pulmonary Emphysema.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/2/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/5/66

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cem

23D. LOCATION

(City, town, or county)

AA Co

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 5 1966

McCully F.H. 237 Patapsco Ave 21225

WALTER H. GEORGE

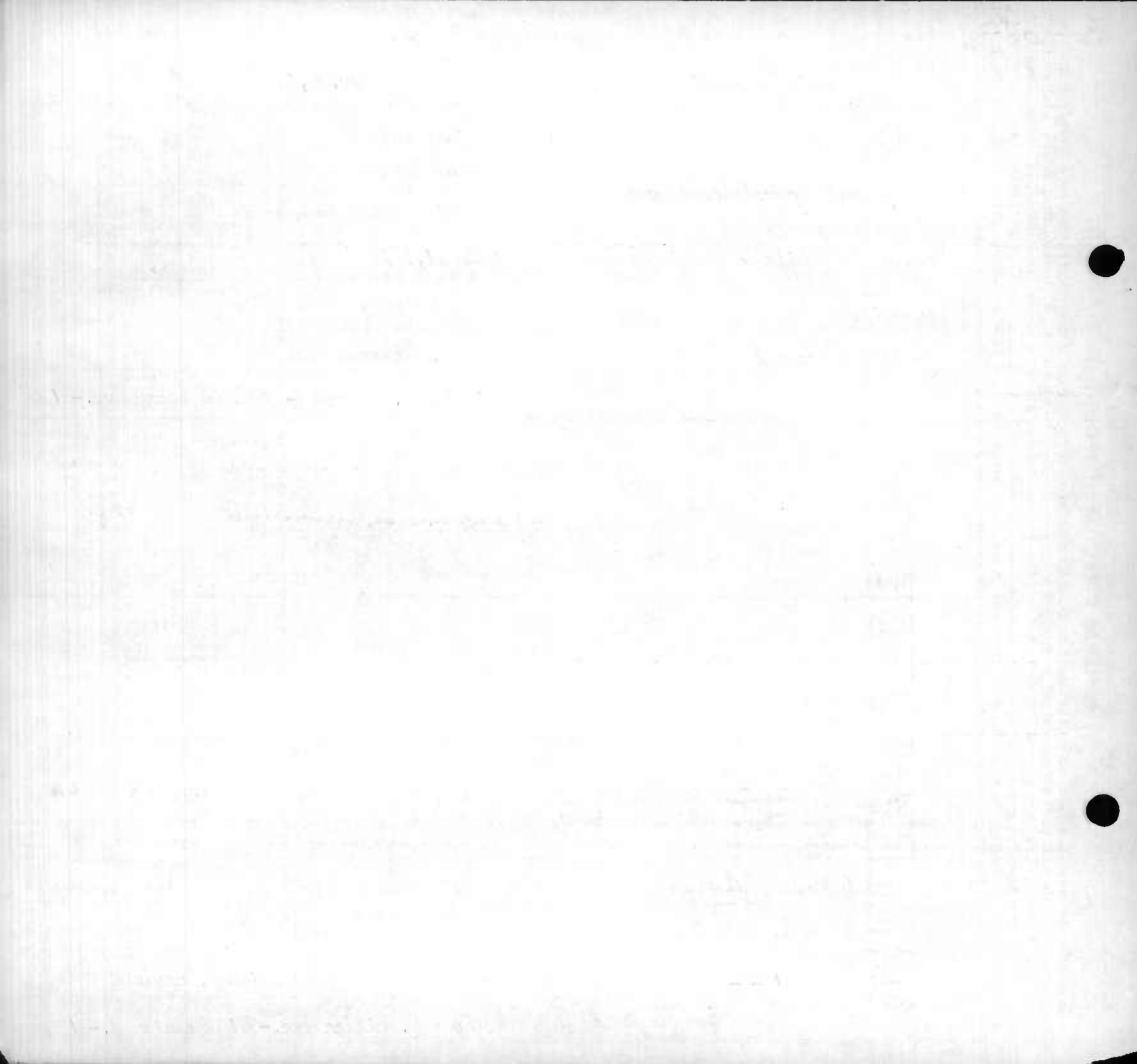
VALLEY HAPER

55 HAD (UN) 1111

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 12107					CERTIFICATE OF DEATH					Registered No. 66 12107				
1. NAME OF DECEASED (Type or Print) <i>Marie Behrendt</i>					2. DATE AND HOUR OF DEATH <i>Nov. 29, 1966</i>					M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Gould Convalescent Home</i>					A. STATE <i>Maryland</i>					B. COUNTY				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					27-01				
					D. STREET ADDRESS (If rural, give location) <i>2817 Pelham Avenue</i>									
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>July 21, 1873</i>		9. AGE (In years lost birthday) <i>93</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Germany</i>				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME <i>Wilhelm Hermari</i>					14. MOTHER'S MAIDEN NAME <i>Theresa Baer</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS <i>William J. Behrendt - 3904 Mayberry Ave. - 21206</i>				
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Anterosclerotic Cardiovascular Disease</i>					CAUSE OF DEATH (A) <i>Anterosclerotic Cardiovascular</i> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <i>30 years</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <i>Arteriosclerosis, generalized</i> DUE TO					<i>30 yr.</i>				
(C)														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 8</i> 19 <i>56</i> to <i>Nov 29</i> 19 <i>66</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Nov 11</i> 19 <i>66</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.														
23A. SIGNATURE <i>Adam G. Swiss</i>								M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>Nov 30, 1966</i>			
23C. PHYSICIAN'S NAME (Type) <i>Adam G. Swiss</i>								23D. ADDRESS M.D. <i>6232 Belair Road Balto. Maryland</i>						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>12-2-66</i>			24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 5 1966</i>				25B. NAME OF REGISTRAR <i>R. G. E. Fisher</i>				25C. FUNERAL DIRECTOR ADDRESS <i>John C. Miller Inc. - 6415 Belair Rd. - 21206</i>						

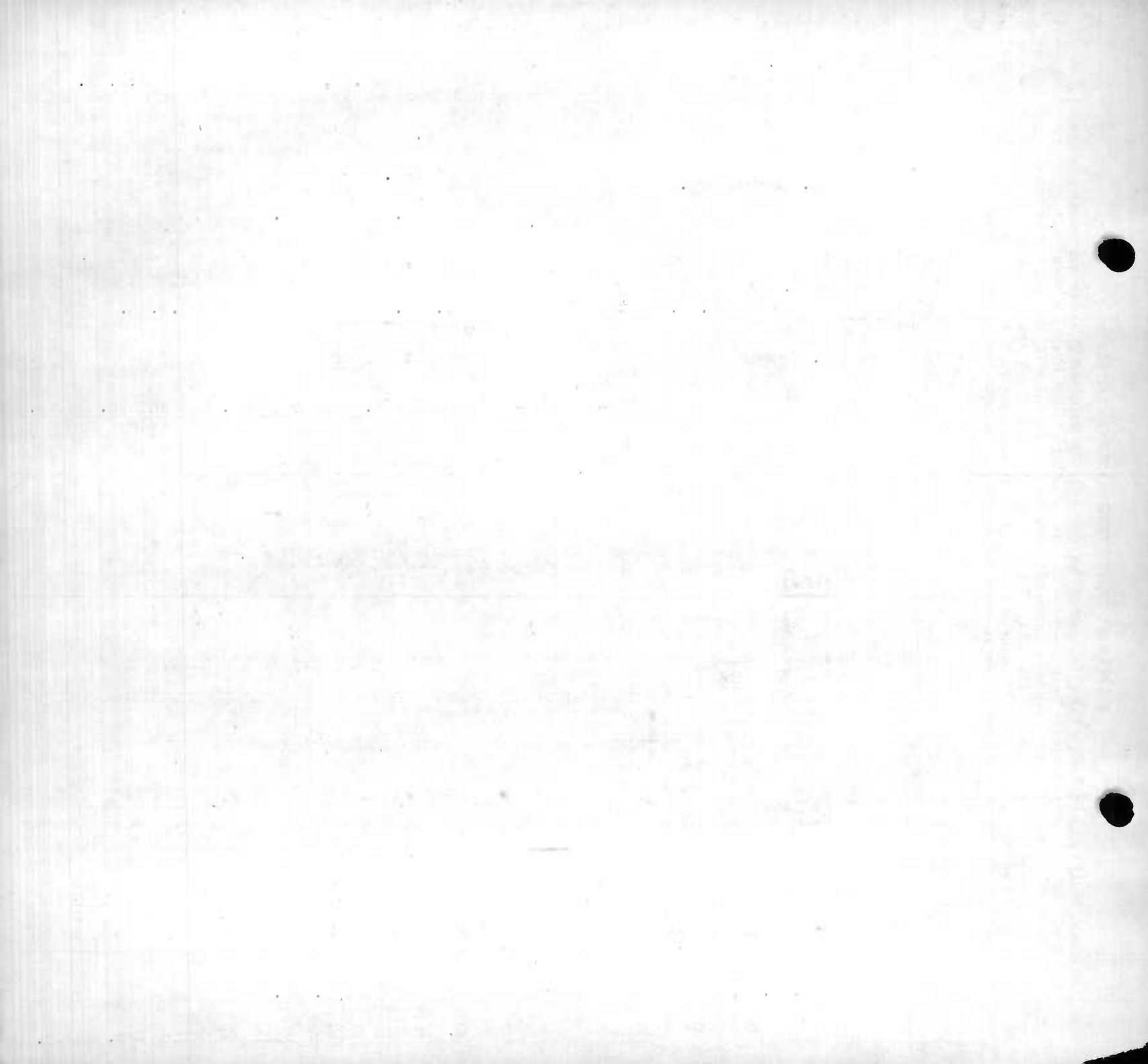




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12108</u>	
BIRTH NO. <u>66 12108</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Henry Kramer</u>		2. DATE AND HOUR OF DEATH <u>Dec. 2, 1966</u>   <u>2; P. M.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>130 S. Loudon Ave.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>20-08</u> D. STREET ADDRESS (If rural, give location) <u>130 S. Loudon Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>June 28, 1895</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U. S. Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
13. FATHER'S NAME <u>Frank M. Kramer</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Kroger</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-24-7450-A</u>		17. INFORMANT <u>Katherine T. Kramer</u> ADDRESS <u>130 S. Loudon Ave. Balto. Md.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>General carcinomatosis</u> <u>Primary focus not determined</u> <u>Myocarditis, Senility</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>0</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 1964</u> 19 to <u>12/2/66</u> 19 that (I) (we) last saw the deceased alive on <u>12/1/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. Calais</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>12/3/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>A CALAIS</u>		23D. ADDRESS M.D. <u>6411 Frederick Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Dec. 5, 1966</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1966</u>		25B. NAME OF REGISTRAR <u>G. Truman Schwab</u>		25C. FUNERAL DIRECTOR <u>3512 Frederick Ave. Balto.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 12109		CERTIFICATE OF DEATH		66 12109	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SLACK, SAMUEL DALLAS			2. DATE AND HOUR OF DEATH DECEMBER 2, 1966 9:20P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL			A. STATE MARYLAND B. COUNTY HOWARD		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) SYKESVILLE		
40			D. STREET ADDRESS (If rural, give location) 63-00		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) MARRIED	8. DATE OF BIRTH 07-13-88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SAMUEL SLACK			14. MOTHER'S MAIDEN NAME KATIE SHIPLEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213 36 4802	17. INFORMANT ADDRESS HOSPITAL SLIP-CATON AND WILKENS AVE.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 3-27-11 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Coronary Artery Failure</i> DUE TO (B) <i>Severe Emphysema</i> DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 21, 19 66 to DECEMBER 2, 19 66, that (X) (we) last saw the deceased alive on DECEMBER 2, 19 66 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ramon U. Suarez</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-7-66
23C. PHYSICIAN'S NAME (Type) RAMON U. SUAREZ			23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-6-1966	24C. NAME OF CEMETERY or CREMATORY Mt. View		24D. LOCATION (City, town, or county) (State) Alpha, Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1966	25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR P.C. Higginbotham		ADDRESS Ellicott City, Md



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12110					CERTIFICATE OF DEATH			Registered No. 66 12110	
1. NAME OF DECEASED (Type or Print) <b>DAVID W. BRAND</b>					2. DATE AND HOUR OF DEATH <b>11/30/66 5AM</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 3936 ELM. AVE. Balto 11, Md.</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>25-42</b> D. STREET ADDRESS (If rural, give location) <b>2536 SOUTH DENE AVE</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	B. DATE OF BIRTH <b>4/4/85</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George Brand</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA VANNEMAN</b>			17. INFORMANT ADDRESS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>150-10-7107</b>						
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute coronary occlusion</b>			CAUSE OF DEATH (A) DUE TO <b>Myocardiosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			(B) DUE TO <b>Cerebral, coronary vascular insufficiency</b>			<b>Years</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(3) strokes, Hypertension</b>			(C) <b>insufficiency</b>			<b>years</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 23</b> 19 <b>59</b> to <b>Nov. 11, 1966</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Nov 11</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date <b>Nov. 30, 1966 5AM.</b> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Henry Armanas</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <b>Nov. 30, 1966</b>				
23C. PHYSICIAN'S NAME (Type) <b>HENRY ARMANAS</b>		23D. ADDRESS <b>2919 Hollins Ferry Rd. Balto 30, Md.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/3/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>NEW CAMDEN</b>		24D. LOCATION (City, town, or county) (State) <b>CAMDEN, N. J.</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Ball's Chapel</b>		ADDRESS <b>3617 Chestnut Ave.</b>			

DEC 5 1966

George Brown

London Jan 1851

(I have the pleasure to  
acknowledge the receipt of  
your letter of the 11th inst.  
concerning the proposed  
improvement of the  
route connecting London  
with the continent)

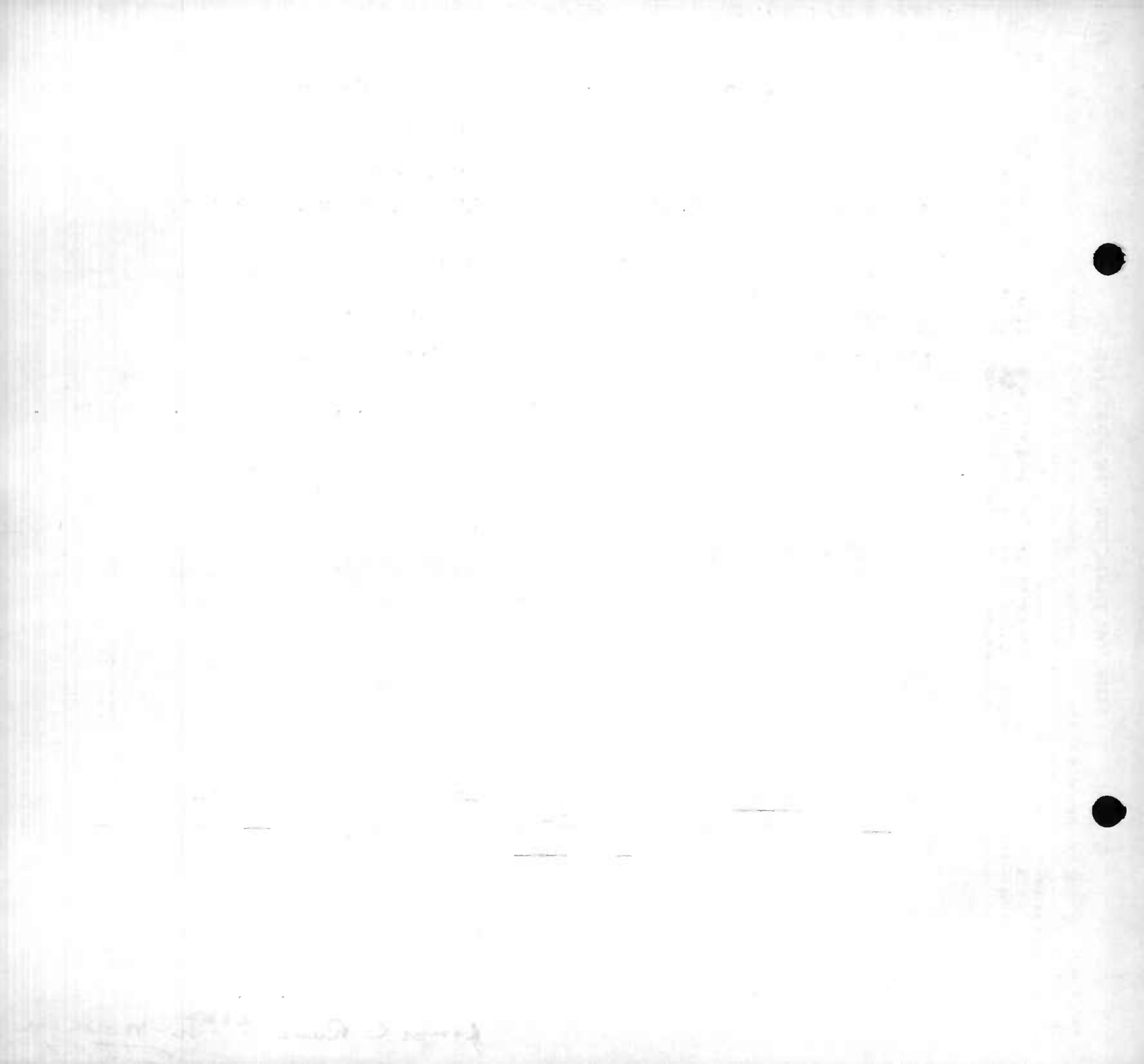
Yours faithfully  
George Brown

Very respectfully  
to the Committee of the  
Great Eastern Railway

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>66 12111</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12111</b>	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		(Type or Print) <b>Mary L. Jones (AKA) Lillian Jones</b>		<b>12-01-66 9:50 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>16-05 Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1215 N. Bentalou Street</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>8-2-85</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>LePlata Md.</b>	
13. FATHER'S NAME <b>Albert Lee</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hawkins</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 56 2971</b>		17. INFORMANT ADDRESS <b>Chauncey A.R. Jones 1215 N. Bentalou St.</b>	
18. <b>133.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>thrombosis</b> <b>Cancer of colon</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>9</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-24 19 66</b> to <b>12-01 19 66</b> , that (I) (we) last saw the deceased alive on <b>12-01 19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. F. Smail Beigi</b>				23B. DATE SIGNED	
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					
23C. PHYSICIAN'S NAME (Type) <b>F. F. Smail Beigi</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/7/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltner</b>		25C. FUNERAL DIRECTOR <b>George E. Russ</b>	
		25D. ADDRESS <b>2222 N. North Ave. Baltimore</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12112	
BIRTH NO. 66 12112		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Robert M. Berger		2. DATE AND HOUR OF DEATH November 30, 1966 7:50 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C.		5. CITY OR TOWN (If outside city limits, write RURAL and give township) rural Baltimore 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION The Mount Convalescent Home 3706 Nortonia Rd.		D. STREET ADDRESS (If rural, give location) 7032 Yataruba Rd.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct. 8, 1877	9. AGE (In years lost birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Berger		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-26-4191		17. INFORMANT Arthur J. Berger 3515 Milford Mill Rd. Zone 7	
18. 4-22-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from March 28 1963 to Nov. 30 1966, that (I) (we) last saw the deceased alive on Nov. 18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED Dec 1, 1966	
23C. PHYSICIAN'S NAME (Type) Abraham B. Hurwitz		23D. ADDRESS M.D. 7501 Liberty Rd. Balto 7, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/21/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) 3801 Frederick Ave. Balto Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 5 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Living & Rogers		25D. ADDRESS 8728 Liberty Rd		25E. ADDRESS Landallville Md	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12113</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>66 12113</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Emma Bootman</u>			2. DATE AND HOUR OF DEATH <u>12-1-1966</u> <u>6:15</u> <u>A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00</u> <u>3402 Chesley Avenue</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-05</u> D. STREET ADDRESS (If rural, give location) <u>3402 Chesley Avenue 21234</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-22-1873</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Andrel Gernand</u>			14. MOTHER'S MAIDEN NAME <u>Annie Fuhmen</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-16-1548D</u>	17. INFORMANT ADDRESS <u>Mr Sherman Bootman 3402 Chesley Avenue</u>		
18. <u>170X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>circulatory failure 2 hrs</u> DUE TO (B) <u>Cancer of the breast 15 yrs</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> <u>1957</u> to <u>12-1-1966</u> , that (I) (we) last saw the deceased alive on <u>11-28</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rigler</u> M.D.				23B. DATE SIGNED <u>12-2-66</u>	
23C. PHYSICIAN'S NAME (Typed) <u>RICHARD R. RIGLER</u>				23D. ADDRESS M.D. <u>1 W. Overlea Ave. Balto. 6, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-5-1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION <u>Baltimore</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1966</u>		25B. NAME OF REGISTRAR <u>R. E. F. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>2401 Bldg Road (30)</u>	

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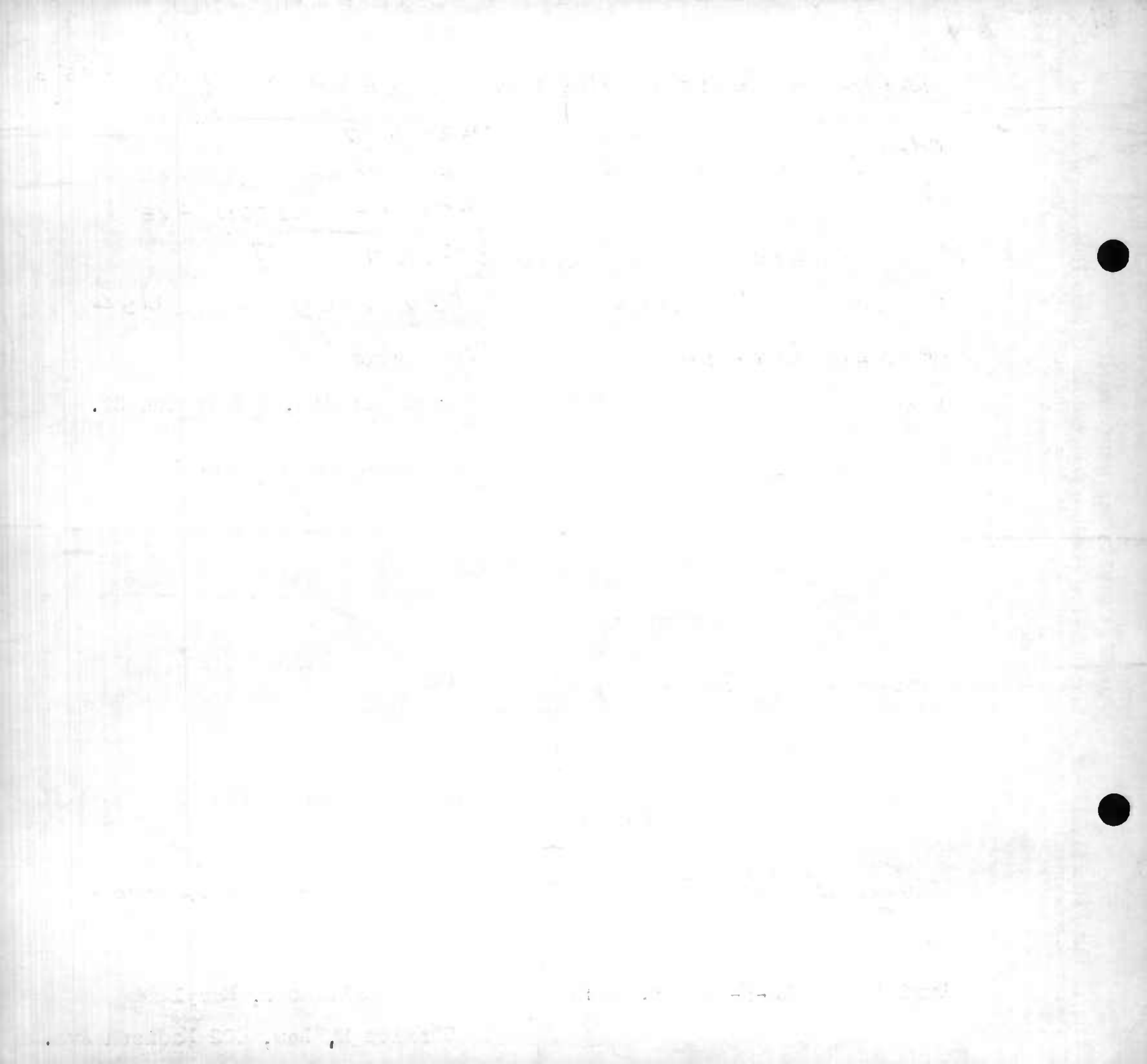
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✓ *Diary*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 12114</b>		Baltimore City Health Department <b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 12114</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>KENNETH RUSTIN MASON</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 1 1966 2<sup>05</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>801 NEWINGTON AVE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b>		(If not in hospital or institution, give street address or location)			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>3-25-59</b>	9. AGE (In years last birthday) <b>7</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Herman Cornish</b>		14. MOTHER'S MAIDEN NAME <b>Joan Mason</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Herman Cornish, 801 Norton St.</b>	
18. <b>237X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>POSTERIOR FOSSA BRAIN TUMOR</b> DUE TO (A) <b>POSTERIOR FOSSA BRAIN TUMOR</b> (B) <b>POSTERIOR FOSSA BRAIN TUMOR</b> (C) <b>POSTERIOR FOSSA BRAIN TUMOR</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION <b>11-30-66</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BRAIN TUMOR</b>		21C. AUTOPSY? (Yes or No) <b>No</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 29</b> 19 <b>66</b> to <b>Dec 1</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 1</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.					
23A. SIGNATURE <b>Larry E. Fleischer</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-1-66</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-5-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Charles R. Law</b>	
25C. FUNERAL DIRECTOR <b>Charles R. Law</b>		25D. ADDRESS <b>802 Madison Ave.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 12115	
CERTIFICATE OF DEATH				Registered No. _____	
BIRTH NO. _____		66 12115			
M.E. CASE NO. _____					
1. NAME OF DECEASED (Type or Print) <b>Sister Ethel Knight</b>		2. DATE AND HOUR OF DEATH <b>December 1, 1966</b>		<b>11: 50 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>94 Villa Saint Michael</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>4000 Forest Hill Road, Zone 7</b>			
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single - never m.</b>	8. DATE OF BIRTH <b>May 28, 1885</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sister of Charity</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pharmacist-retired</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>					
13. FATHER'S NAME <b>John E. Knight</b>			14. MOTHER'S MAIDEN NAME <b>Anna Marie Palmer</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-54-0236</b>		17. INFORMANT ADDRESS <b>Sister Andrea - same address</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion</b>		CAUSE OF DEATH (A) <b>Coronary occlusion</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>arteriosclerosis</b> DUE TO		<b>11 years</b>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>None</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 1955</b> to <b>November 1966</b> , that (I) (we) last saw the deceased alive on <b>November 29 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D. P. Alagia</b> M.D.				23B. DATE SIGNED <b>December 1, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. P. ALAGIA</b> M.D.				23D. ADDRESS <b>3325 Frederick Avenue, Baltimore, 21228</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/3/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Seton</b>	
24D. LOCATION (City, town, or county) (State) <b>(On Grounds) - Balto - Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Dewar &amp; Snowden - Balto.</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

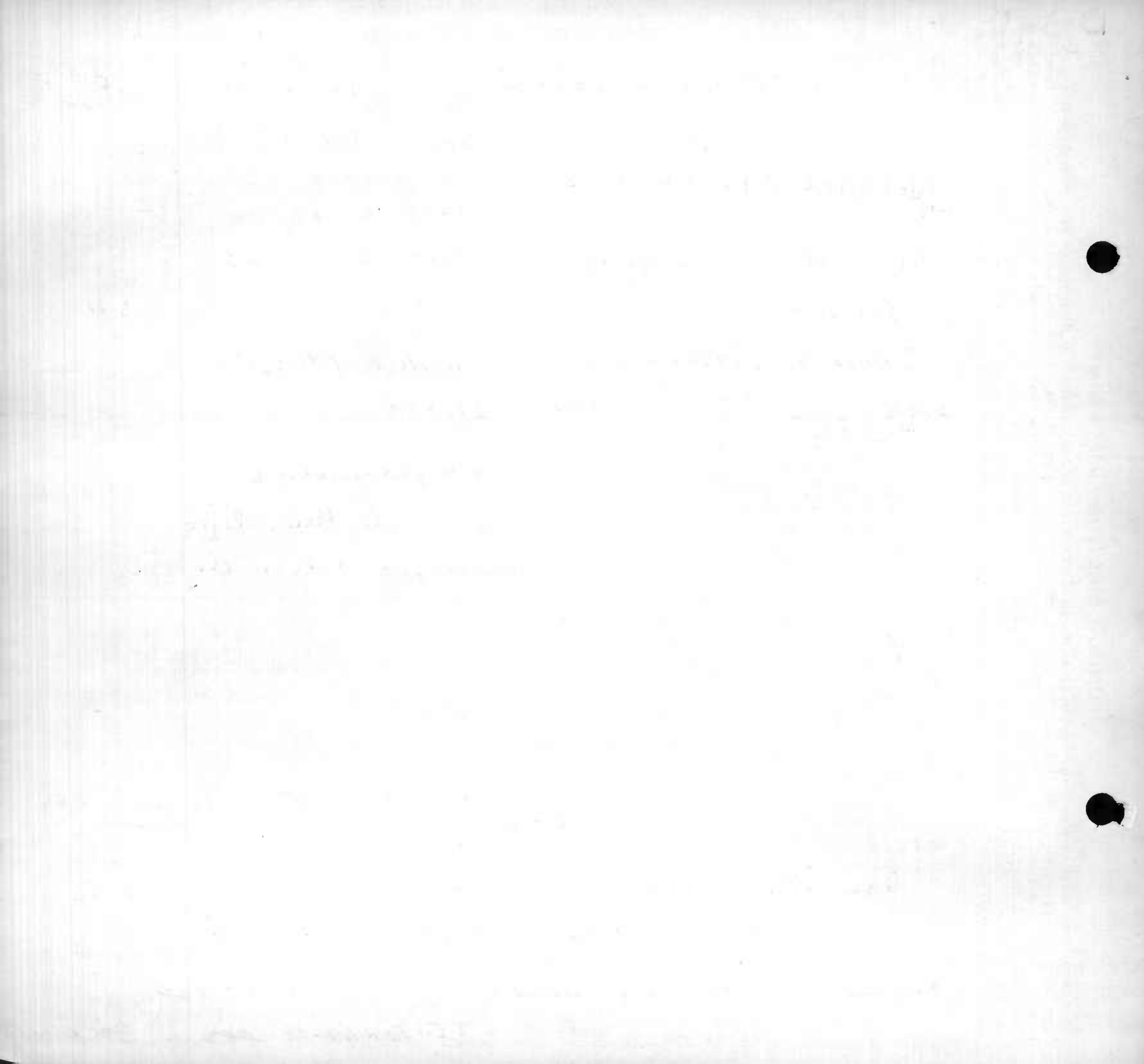
BIRTH NO. 66 12116				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12116	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>DAISY L. HEMLING</b>				2. DATE AND HOUR OF DEATH <b>11/28/66</b>		<b>7 30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI Hosp. of BALTIMORE, Inc.</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE Co.</b>	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>GARRISON</b>		<b>53-00</b>	
				D. STREET ADDRESS (If rural, give location) <b>KENMAR AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>CAU.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WID.</b>	8. DATE OF BIRTH <b>10/8/82</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Charles Rote</b>			14. MOTHER'S MAIDEN NAME <b>Sally Derr</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO none</b>			16. SOCIAL SECURITY NO. <b>1-11-111111</b>			17. INFORMANT <b>Mrs. John Hundertmark</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro-Vascular Accident</b>			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>			20. INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 wks.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II Carcinoma of Breast</b>			21. SPONCHO PNEUMONIA <b>5 years</b>			<b>2 wks.</b>	
19A. DATE OF OPERATION <b>11/6/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Quadriceps Tendon</b>		20A. AUTOPSY? (Yes, or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>GARRISON, MD.</b>			
21D. TIME OF INJURY (APPROX.) <b>11/5/66</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>FALL AT HOME</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>11/5/66</b> to <b>11/28/66</b> , that (we) last saw the deceased alive on <b>11/28/66</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Brett Lazar</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/28/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. BRETT LAZAR</b>				23D. ADDRESS <b>Sinai Hosp. of Baltimore, Inc.</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/28/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Stone Chapel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>John E. Felt</b>		25C. FUNERAL DIRECTOR <b>Frank H. Newell</b>		ADDRESS <b>Pikesville, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12117</b>	
BIRTH NO. <b>66 12117</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>DITTLEMAYER PETER</b>	
2. DATE AND HOUR OF DEATH <b>12-2-66 10<sup>15</sup> P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MELCHOR NURSING HOME</b>		A. STATE <b>MD</b> B. COUNTY <b>BALTO Co.</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ROSEDALE 53-00</b>	
D. STREET ADDRESS (If rural, give location) <b>1818 WOODRUFF AVE</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3/20/83</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>73</b>
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>US IT</b>	
13. FATHER'S NAME <b>JAMES DITTLEMAYER</b>		14. MOTHER'S MAIDEN NAME <b>MARY PHILLIPS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>SISTER</b>		ADDRESS	
18. <b>331X I</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Bronchopneumonia</b> DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>C.V.A. L. side Hemiplegia</b> DUE TO	
		(C) <b>Generalized arteriosclerosis</b>	
<b>II</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-22-1965</b> to <b>12-2-1966</b> , that (I) (we) last saw the deceased alive on <b>12-2-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Cesar Valle Caverio</b>		23B. DATE SIGNED <b>12-3-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAVERIO M.D.</b>		23D. ADDRESS <b>8629 Liberty Rd</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/5/66</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Carmel</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>J.C. CONNELLY SONS</b>		ADDRESS <b>300 MAC</b>	



66 12118

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12118

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARTHA

DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

November 30, 1966

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2928 Garrison Boulevard

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

4-26-1944

9. AGE (In years  
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

Halifax Co. Va

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Andrew Britton

14. MOTHER'S MAIDEN NAME

Paris M. Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

Mr Davis 2928 Garrison Blvd

18. E954X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia during Anesthesia for Dental  
Extraction.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.Thromboses of ovarian veins, with multiple  
small embolization to pulmonary artery.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Office

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1944 Druid Hill Avenue

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11 30 '66 P

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒21F. HOW DID INJURY OCCUR?  
Therapeutic misadventure during nitrous  
oxide-oxygen anesthesia.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/30/66

23A. BURIAL CREMATION

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Received of the  
Treasury of the  
United States  
the sum of \$100.00  
for the purchase of  
the land of the  
United States  
at the price of \$1.00  
per acre.

Witness my hand and  
the seal of the  
United States  
at Washington  
this 1st day of  
January 1864.

James A. Smith  
Secretary of the  
United States  
Department of the  
Interior

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12119</span>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <span style="font-size: 1.5em;">66 12119</span></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Maria Christofaro</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">12.20 PM. Dec. 1, 1966 M.</span>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Bon Secours Hospital 34</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">BALTIMORE</span> B. COUNTY <span style="font-size: 1.2em;">26-10</span> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE 24 Md.</span> <b>D. STREET ADDRESS</b> (If rural, give location) <span style="font-size: 1.2em;">3305 LEVERTON AVE</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">WIDOWED</span>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">1-22-1910</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">56</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">housewife</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">—</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Italy</span>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">Italy</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">DOMENICO GUATTIERI</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">MARIA CORASANTI</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">—</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">—</span>			<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mr. Vincent Cristofaro - 3305 Leverton</span>		
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">450.01 Arteriosclerotic vascular disease</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">II</span>			INTERVAL BETWEEN ONSET AND DEATH 		
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> 					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> 		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">no</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.) 		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) 	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) 		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> 	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">11 - 19 1966</span> <b>to</b> <span style="font-size: 1.2em;">12 - 1 1966</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">12 - 1 1966</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Blanca L. Buffis</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">12 - 1 - 66</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">L Serra</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Bon Secours Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) 		<b>24B. DATE</b> <span style="font-size: 1.2em;">12/8/66</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> 	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Italy</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">DEC 5 1966</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fairman</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Joseph D. Zammone Jr.</span>			

Domenico Gualtieri

F. married

Italy

Marin Carraresi

1-15-1910 20

3302 Levee St. N.W.

Don Giovanni Hospital

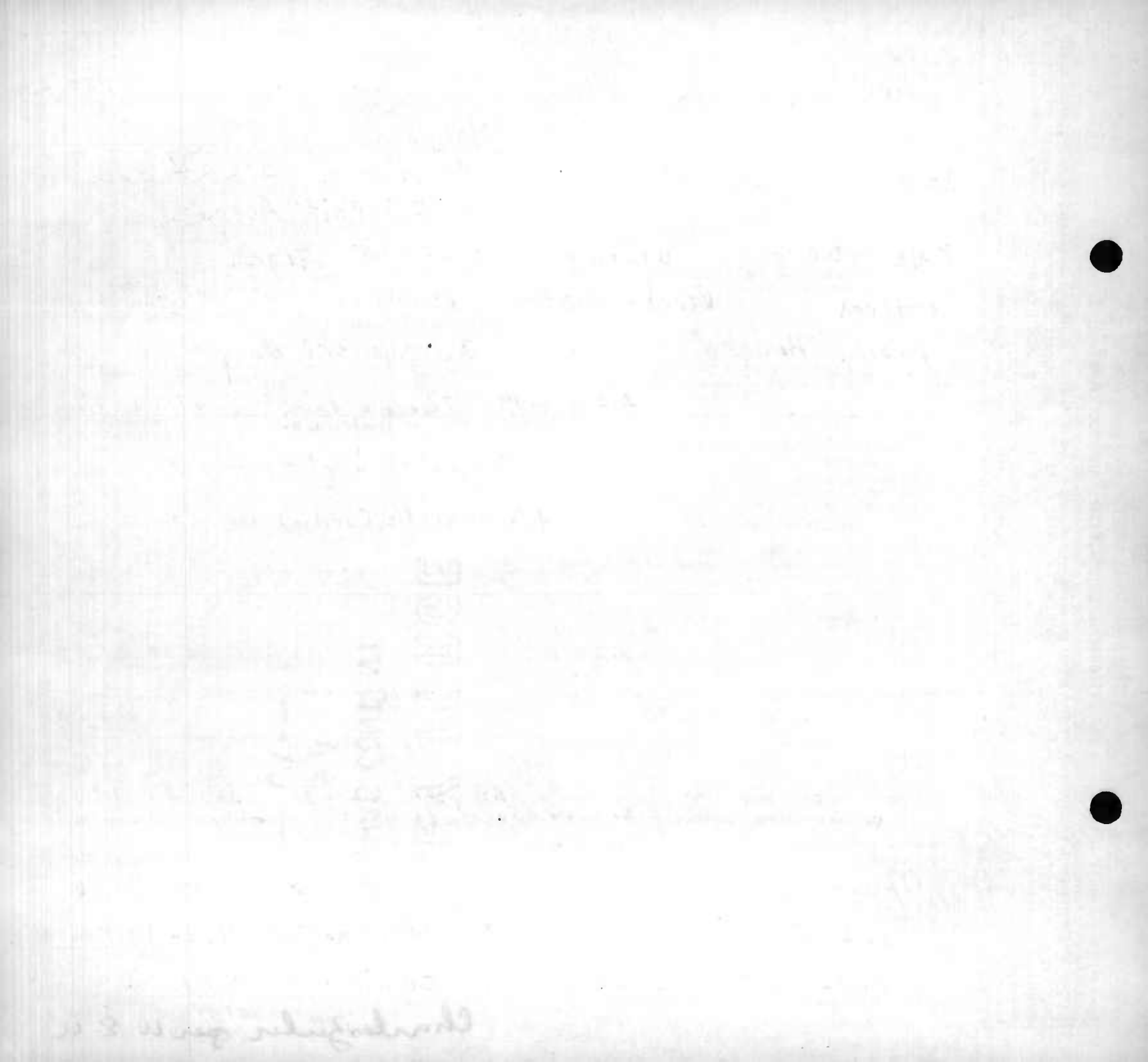
24 P.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12120</u>	
BIRTH NO. <u>66 12120</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Knack, John W.</u>		2. DATE AND HOUR OF DEATH <u>12/1/66</u> <u>1:20 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>North Charles General Hospital</u> <u>49</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21224</u> <u>26-09</u>			
		D. STREET ADDRESS (If rural, give location) <u>3723 Fair Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>5-15-95</u>	9. AGE (In years last birthday) <u>71 yrs.</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Board of Education</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>Knack, ANDREW</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-01-6247</u>		17. INFORMANT <u>Theodore Knack</u> <u>624 St. Dunstons Rd.</u>	
18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Balto. MD.</u> (A) <u>Congestive heart failure</u> DUE TO (B) <u>Atherosclerotic Cardiovascular disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>12-1-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 12, 1966</u> to <u>December 1st, 1966</u> , that (I) <u>(did)</u> last saw the deceased alive on <u>November 30, 1966</u> and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(did)</u> <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>James Hardy</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>12-1-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. A. SILVER</u>				23D. ADDRESS M.D. <u>6210 Park Heights Ave. Baltimore MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-5-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>SACRED HEART CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>7401 GERMAN HALL RD. BA. CO., MD.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Charles Ziller</u> <u>901 S. CONKLING ST. #24</u>	



B-420

66 12121

BALTIMORE CITY HEALTH DEPARTMENT

66 12121

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILMER Earle BLEACH

2. DATE AND HOUR PRONOUNCED DEAD

December 1, 1966 2:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Balt.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2901 Dunglew Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 27, 1901

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Timekeeper

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Bleach

14. MOTHER'S MAIDEN NAME

Cora Barber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Florence Bleach 2901 Dunglew Road

18. 292.3

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Anemia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Myeloid Metaplasia.  
DUE TO

(C).....

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)Charles S. Petty  
Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/2/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/5/66

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

(City, town, or county)

Overlea, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

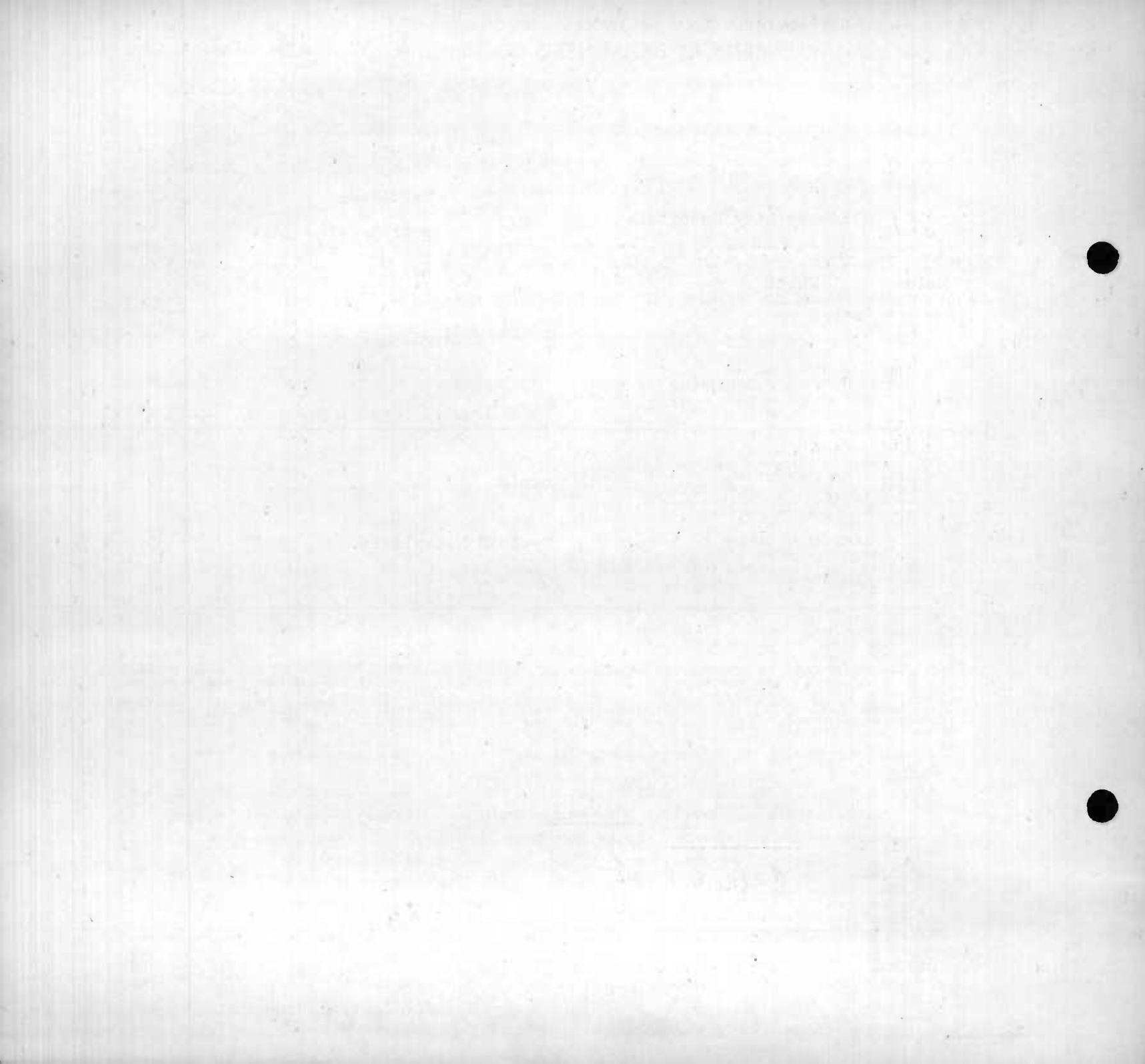
24C. FUNERAL DIRECTOR

ADDRESS

DEC 5 1966

Robert E. Farley

Ulrich Funeral Home Dundalk, Md.



# FUNERAL DIRECTOR: IMPORTANT

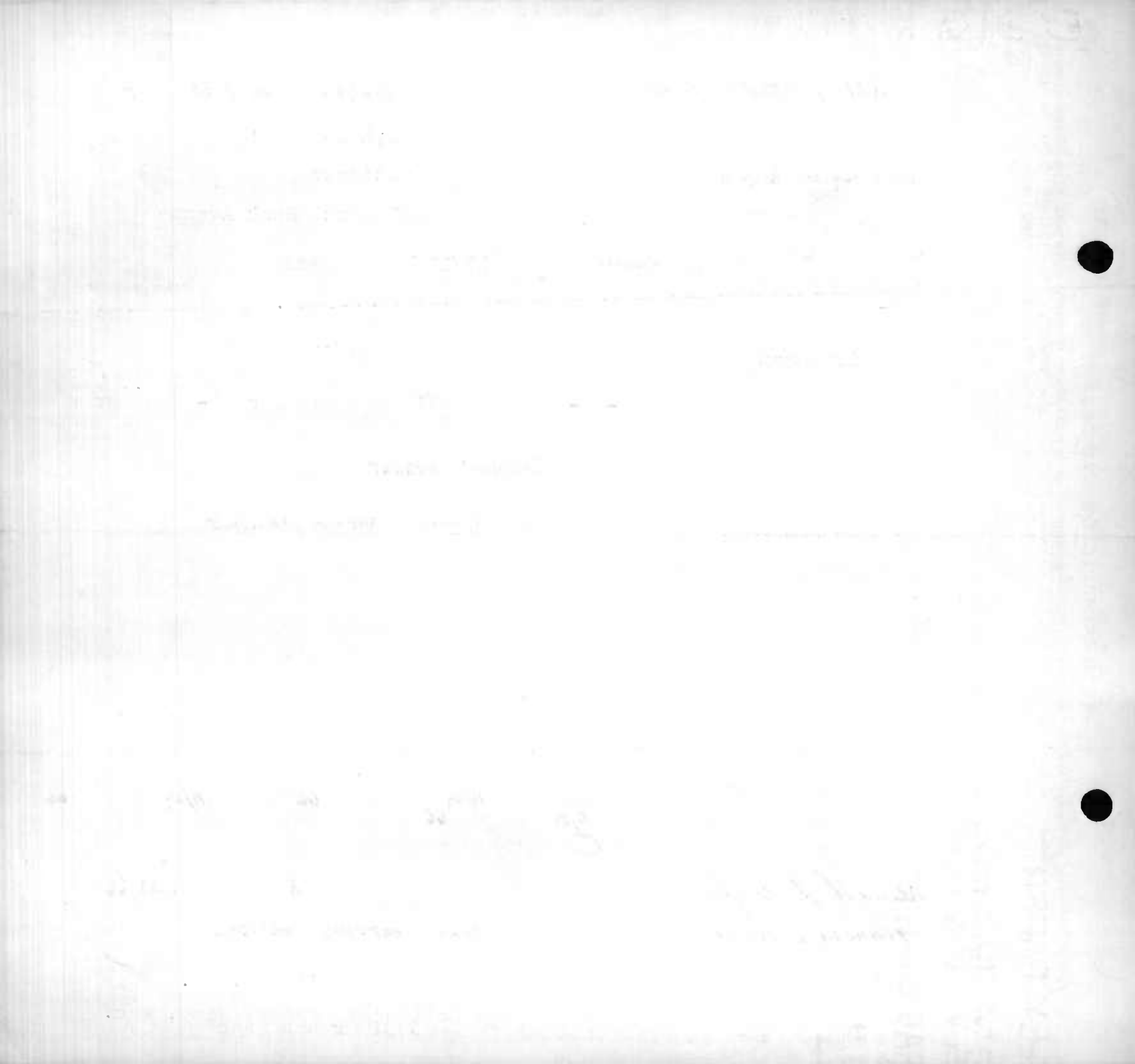
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12122</u>	
BIRTH NO. <u>66 12122</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>25CHUNKE, ANNA ELIZABETH</u>		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <u>NOV. 30, 1966</u> <u>1:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>BALTIMORE</u>	
<u>36 FRANKLIN SQUARE HOSP.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<u>8-01</u>	
		D. STREET ADDRESS (If rural, give location)		<u>3418 CARDENAS AVE.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH <u>3-28-1898</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>FREDERICK RICHARD</u>		14. MOTHER'S MAIDEN NAME <u>MARY SATER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>216 09 9436</u>		17. INFORMANT <u>WALTER RADDERS</u> ADDRESS <u>1913 SWANSEA RD.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I		A. <u>ACUTE MYOCARDIAL INFARCTION</u>			
II		B. <u>—</u>			
C. <u>—</u>		D. <u>—</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		PNEUMONIA, RT. BASE			
19A. DATE OF OPERATION <u>0.</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>NOV 28</u> 19 <u>66</u> to <u>NOV 30</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>NOV. 30</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Laizis</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>NOV 30, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>MILAGROSA R. CALIXTO</u>		23D. ADDRESS <u>FRANKLIN SQUARE HOSP. BALTIMORE, MARYLAND</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/3/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE</u>		(State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Edwards</u>		25C. FUNERAL DIRECTOR <u>William J. Zinnel</u> ADDRESS <u>Home-420 BELAIR</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12123				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12123	
M.E. CASE NO.				1. NAME OF DECEASED or Katie			
(Type or Print) KATIE ESPEY				2. DATE AND HOUR OF DEATH 11/29/66 1:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
JONAS HOPKINS HOSPITAL				Maryland			
3.3				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
D. STREET ADDRESS (If rural, give location)				26-10			
				407 North East Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
F	W	WIDOWED	12/22/80	85	Char-woman		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Char-woman			Monumental Bus Co	Baltimore, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Hirschman				unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
				219-18-1431	1569 Glen Keith Blvd., 21204 Muriel Vogelsand, grand-daughter		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) CARDIAC ARREST			
ANTECEDENT CAUSES				(B) NOT KNOWN - ANEMIA, JAUNDICE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
2		yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?					
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from 11/29 1966 to 11/29 1966, that (I) (we) last saw the deceased alive on 11/29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Kenneth L. Brigham						11/29/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
KENNETH L. BRIGHAM				JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)				
Burial	12/3/66	Baltimore Cemetery	Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR			ADDRESS		
DEC 5 1966	ALBERT E. FORD	Schimunek Funeral Home, Inc.			3331 Brehms Lane		





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12124

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FRANKLIN

Joseph

HAJEK

2. DATE AND HOUR PRONOUNCED DEAD

November 30, 1966

8:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland 21236

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

53-00

D. STREET ADDRESS (If rural, give location)

4221 Soth Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
married

8. DATE OF BIRTH

1/8/1923

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Mail Carrier

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Post Office

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Hajek

14. MOTHER'S MAIDEN NAME

Anna Cherney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

Navy WW 2

16. SOCIAL  
SECURITY NO.

218-18-2547

17. INFORMANT

ADDRESS

Elsie Pridgeon Hajek, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/5/66

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 5

1966

24B. NAME OF REGISTRAR

Robert E. Fajkus

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

ADDRESS

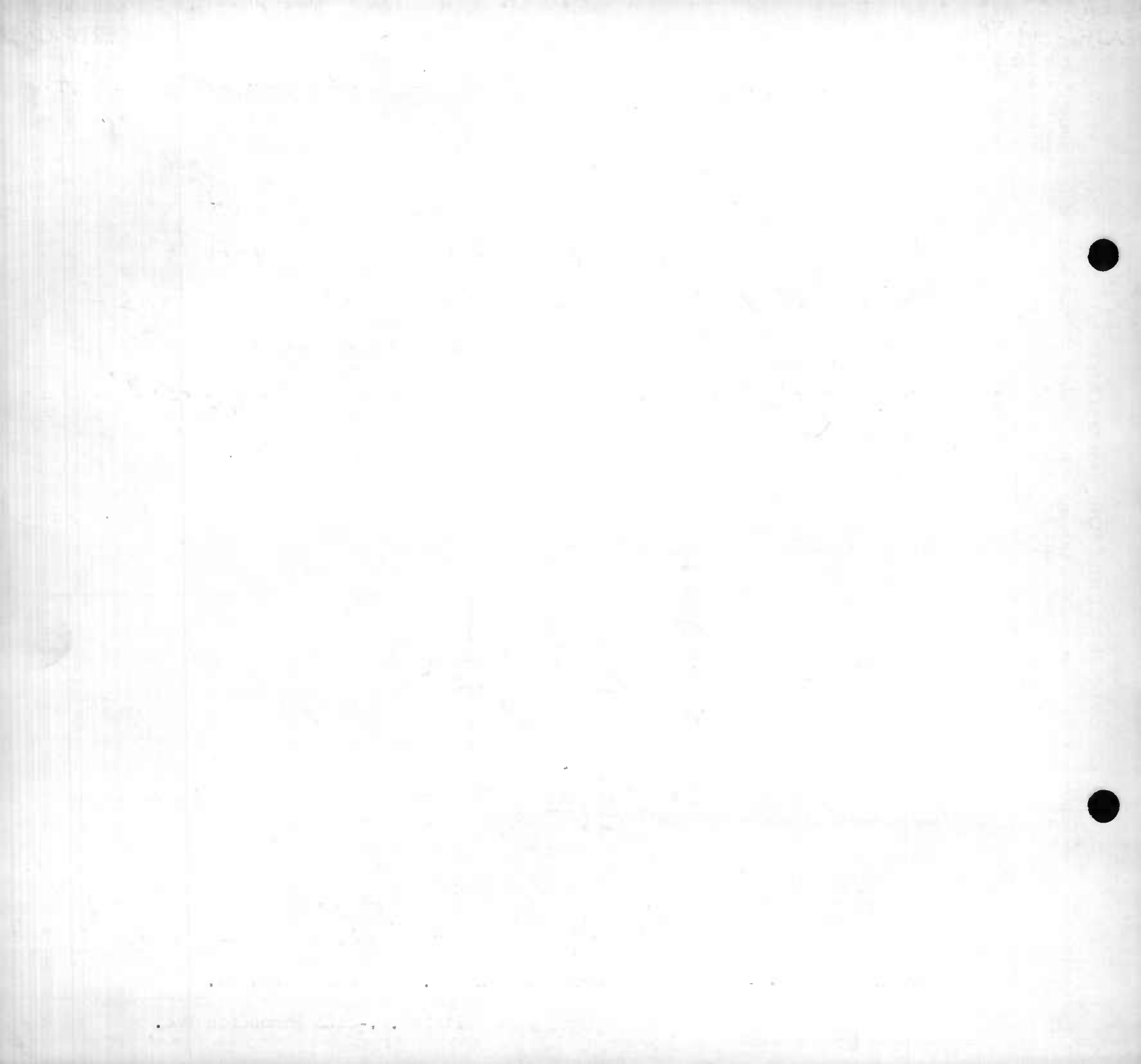
WALTER H. BOND  
JAN 1 1900

Walter H. Bond

**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12125	
BIRTH NO. 66 12125		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>THOMAS EDWARD SCHELL</b>		2. DATE AND HOUR OF DEATH <b>Dec 2/66 5 A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 342 N. Hilton St Balto 29 Md</b>		A. STATE <b>Md</b> B. COUNTY <b>Balto</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto</b>			
		D. STREET ADDRESS (If rural, give location) <b>342 N Hilton St.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>May 8/1922</b>	9. AGE (In years last birthday) <b>44</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Vending machines</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Schell</b>		14. MOTHER'S MAIDEN NAME <b>Flurence Harrison</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-14-4067</b>		17. INFORMANT <b>John Schell</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion</b>		CAUSE OF DEATH (A) DUE TO <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>arteriosclerosis</b>			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>✓</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>✓</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>✓</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>✓</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>✓</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>✓</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 1 1965</b> to <b>Dec 2 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 27 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. N. Mac MURPHY</b>				23B. DATE SIGNED <b>Dec 2/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. N. MAC MURPHY</b>				23D. ADDRESS <b>607 Penna Ave. Balto 1 Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-5-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>DEC 5 1966</b>		25C. FUNERAL DIRECTOR <b>Witzke F. D. 4101 Edmondson Ave.</b>	



S-360

66 12126

BALTIMORE CITY HEALTH DEPARTMENT

66 12126

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

STANLEY F. SOUDER

2. DATE AND HOUR PRONOUNCED DEAD

December 3, 1966

1:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

36  
99 Franklin Square Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1013 De Soto Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

6-26-1912

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CHAUFFEUR

10B. KIND OF BUSINESS OR INDUSTRY

TRUCK

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN SOUDER

14. MOTHER'S MAIDEN NAME

ROSE ARNOLD

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL  
SECURITY NO.

216-32-5115

17. INFORMANT

ELEANOR DANIEL

ADDRESS  
GLENBURNIE MD.

102 POPLAR AVE

18.

443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) ~~HEART~~

Hypertensive and arteriosclerotic  
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPT? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)  
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK

NOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

12-7-66

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEM.

23D. LOCATION

BALTIMORE, MARYLAND.

24A. DATE REC'D BY HEALTH DEPT.

DEC 5 1966

24B. NAME OF REGISTRAR

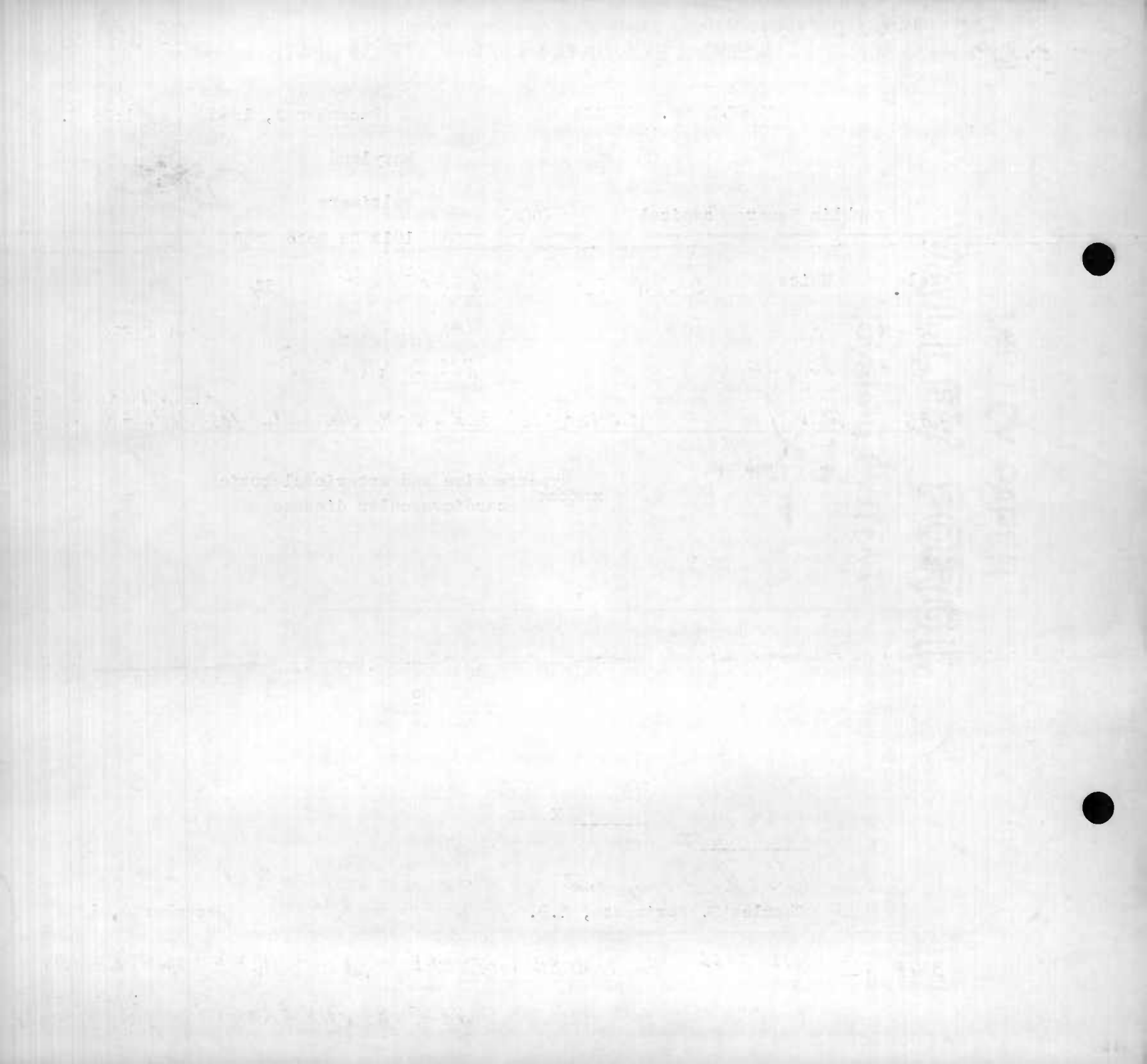
Robert E. Jackson

24C. FUNERAL DIRECTOR

WALTERS FUNERAL HOME

ADDRESS

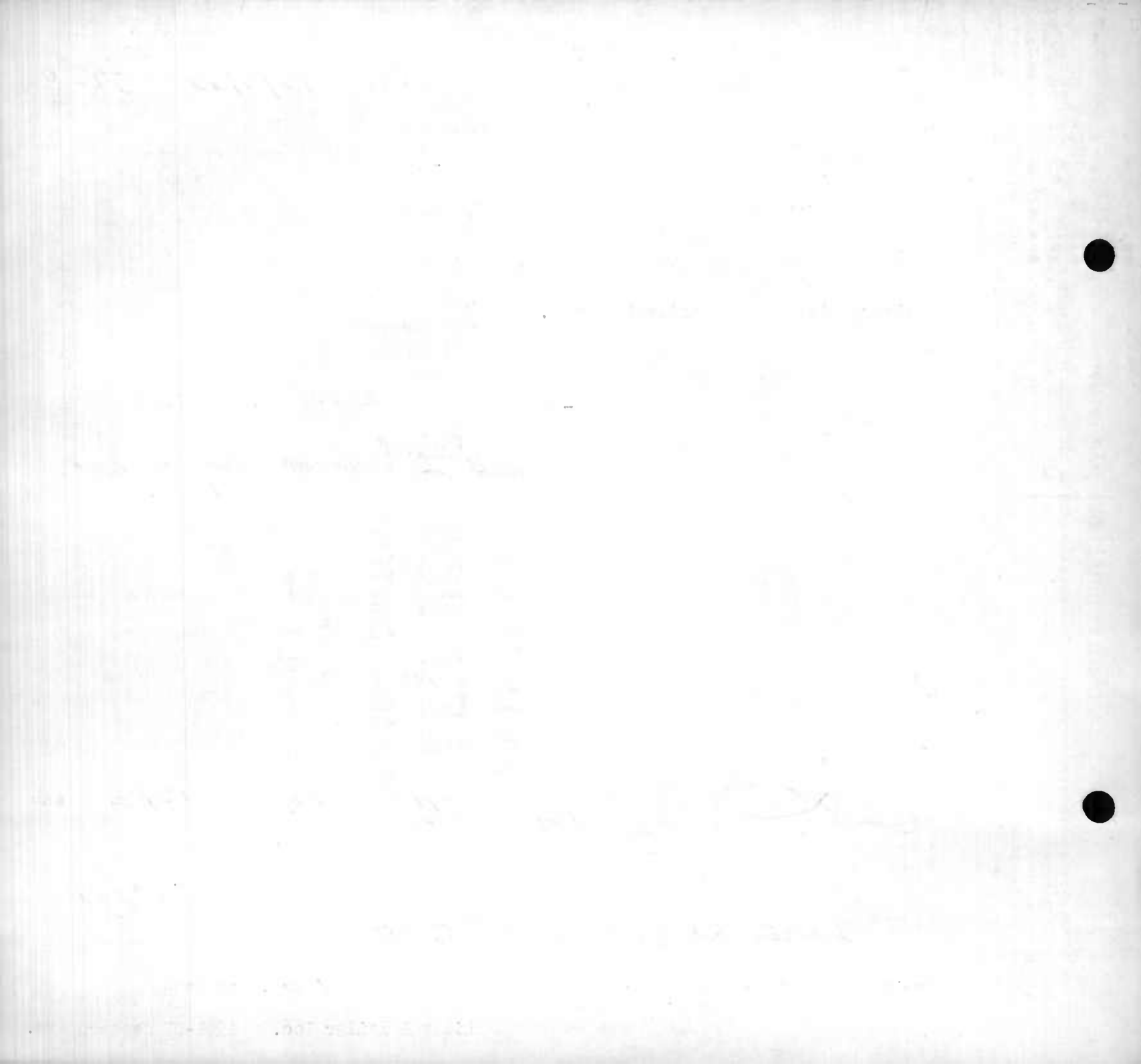
PRATT +  
STRICKER STS.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12127	
<div> <div>66 12127</div> <div>CERTIFICATE OF DEATH</div> </div>					
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED (Type or Print)</div> <div>CARLTON L. SCHILLING</div> <div>Carlton Schilling</div> </div>			<div> <div>2. DATE AND HOUR OF DEATH</div> <div>12/3/66 540 P.M.</div> </div>		
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> <div>BALTIMORE CITY HOSPITALS</div> <div>4940 EASTERN AVENUE</div> <div>BALTO., MARYLAND 21224</div> </div> </div>			<div> <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div> <div>A. STATE</div> <div>MARYLAND</div> <div>B. COUNTY</div> </div> <div> <div>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</div> <div>BALTIMORE</div> <div>D. STREET ADDRESS (If rural, give location)</div> <div>419 N. DUNCAN STREET #21224</div> </div> </div>		
<div> <div>5. SEX</div> <div>MALE</div> </div>	<div> <div>6. RACE</div> <div>WHITE</div> </div>	<div> <div>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</div> <div>SEPARATED</div> </div>	<div> <div>8. DATE OF BIRTH</div> <div>8/03/07</div> </div>	<div> <div>9. AGE (In years last birthday)</div> <div>59</div> </div>	<div> <div>If Under 1 Yr. Months Days</div> <div>If Under 24 Hrs. Hours Min.</div> </div>
<div> <div>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Baltimore City</div> </div>		<div> <div>10B. KIND OF BUSINESS OR INDUSTRY</div> <div>Sanitation Dept.</div> </div>		<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>MARYLAND</div> </div>	
<div> <div>13. FATHER'S NAME</div> <div>FRANK</div> </div>			<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>MARY HOFFMAN</div> </div>		
<div> <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> </div>		<div> <div>16. SOCIAL SECURITY NO.</div> <div>215-01-0487</div> </div>		<div> <div>17. INFORMANT ADDRESS</div> <div>RECORDS: BCH 4940 EASTERN AVENUE #21224</div> </div>	
<div> <div>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</div> <div>163X1</div> </div>			<div> <div>CAUSE OF DEATH</div> <div>(A) DUE TO</div> <div>Small Cell Carcinoma - Lung</div> <div>(B) DUE TO</div> <div>(C)</div> </div>		
<div> <div>18. ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> </div>			<div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>5 mos.</div> </div>		
<div> <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> </div>					
<div> <div>19A. DATE OF OPERATION</div> </div>		<div> <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> </div>		<div> <div>20A. AUTOPSY? (Yes or No)</div> <div>No</div> </div>	
<div> <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div> </div>		<div> <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> </div>		<div> <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> </div>	
<div> <div>21D. TIME OF INJURY (APPROX.)</div> </div>		<div> <div>21E. INJURY OCCURRED</div> <div>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div> </div>		<div> <div>21F. HOW DID INJURY OCCUR?</div> </div>	
<div> <div>22. I certify that (this hospital) attended the deceased from 10/18 1966 to 12/3 1966.</div> <div>that (I) lost saw the deceased alive on 12/3 1966 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.</div> </div>					
<div> <div>23A. SIGNATURE</div> <div>Daniel G. Robinhold</div> <div>M.D.</div> </div>				<div> <div>23B. DATE SIGNED</div> <div>12/3/66</div> </div>	
<div> <div>23C. PHYSICIAN'S NAME (Type)</div> <div>DANIEL G. ROBINHOLD</div> <div>M.D.</div> </div>				<div> <div>23D. ADDRESS</div> <div>BCH. 4940 EASTERN AVE. #21224</div> </div>	
<div> <div>24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>		<div> <div>24B. DATE</div> <div>12-6-1966</div> </div>		<div> <div>24C. NAME of CEMETERY or CREMATORY</div> <div>Parkwood</div> </div>	
<div> <div>24D. LOCATION (City, town, or county) (State)</div> <div>Baltimore, Maryland</div> </div>					
<div> <div>25A. DATE REC'D BY HEALTH DEPT.</div> <div>DEC 5 1966</div> </div>		<div> <div>25B. NAME OF REGISTRAR</div> <div>Robert E. Fisher</div> </div>		<div> <div>25C. FUNERAL DIRECTOR ADDRESS</div> <div>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</div> </div>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12128		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12128	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) FRANCES T. GIZA			2. DATE AND HOUR OF DEATH 12/3/66 11:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 202 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1723 BANK ST.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1/13/93	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE Md	
13. FATHER'S NAME FRANK STANIEC			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-34-9226		17. INFORMANT FRANCES GIZA 1723 BANK ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422141260X CHF ASCVD INTERVAL BETWEEN ONSET AND DEATH 1 WEEK @ LEAST 2 mos.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS					
19A. DATE OF OPERATION 11/12/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE LEG		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/26 19 66 to 12/3 19 66, that (I) (we) last saw the deceased alive on 12/3 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David J. Gillis M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 12/3/66	
23C. PHYSICIAN'S NAME (Type) DAVID J. GILLIS		23D. ADDRESS MERCY HOSP. - BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/7/66		24C. NAME of CEMETERY or CREMATORY ST. STANISLAUS	
24D. LOCATION (City, town, or county) (State) BALTIMORE, Md					
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Georgie A. Weber 705 S Ann st	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12129		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12129	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) James Nowak James NOVAK			2. DATE AND HOUR OF DEATH Dec 2 '66 11205 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 220 S. Wolfe St.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 3-4-14	9. AGE (In years last birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John D. Nowak Leon John Novak			
14. MOTHER'S MAIDEN NAME Carrie Paske		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 43-45			
16. SOCIAL SECURITY NO. 218-01-3245		17. INFORMANT ADDRESS BCH: Records 4940 Eastern Ave. Baltimore, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 019.2 I 322.2 Miliary TB			INTERVAL BETWEEN ONSET AND DEATH 3 months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			alcoholism, malnutrition years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 1 '66 19 to Dec 2 '66 19 that (I) (we) last saw the deceased alive on Dec 1 '66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vincent Felitti			23B. DATE SIGNED Dec 2 '66		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Vincent Felitti			23D. ADDRESS 4940 Eastern Ave. Baltimore, Maryland # 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/66		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 5 1966			
25B. NAME OF REGISTRAR Robert E. Stolley		25C. FUNERAL DIRECTOR George A. Weber 205 South Ann Street			



G. 600

66 12130

BALTIMORE CITY HEALTH DEPARTMENT

66 12130

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROSE GOAR

2. DATE AND HOUR PRONOUNCED DEAD

December 3, 1966 4:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home and Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY X

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

247 N. Spring Court

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

6-17-1902

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Auburn Smith

14. MOTHER'S MAIDEN NAME

Berella Beach

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Charles Gore

ADDRESS

4237 Chapel St

18.

420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cardiac tamponade  
ruptured myocardial infarct

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

Due to: Arteriosclerotic heart disease

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S Charles S. Springate, M.D.  
NAME (Type)CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-8-66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cent

23D. LOCATION

(City, town, or county)

Brooklyn

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 5 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Elroy C. Wilson 1000 B. County Rd

ADDRESS

VALLEY PARK

W. H. L. PROPOSE

CHURCH

W. H. L. PROPOSE

W. H. L. PROPOSE

W. H. L. PROPOSE

W. H. L. PROPOSE

W. H. L. PROPOSE

W. H. L. PROPOSE

W. H. L. PROPOSE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 12131					CERTIFICATE OF DEATH					Registered No. 66 12131				
1. NAME OF DECEASED (Type or Print) <b>LILLIAN MARIE NELSON</b>										2. DATE AND HOUR OF DEATH <b>12-2-66 4:20 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL OF MARYLAND</b>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>MORELAND AVE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE MARYLAND</b> D. STREET ADDRESS (If rural, give location) <b>15-03</b>				
5. SEX <b>FEMALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>11-8-09</b>		9. AGE (In years last birthday) <b>57</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>					13. FATHER'S NAME <b>ARTHUR LEWIS</b>				
14. MOTHER'S MAIDEN NAME <b>SARAH COLLINS</b>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>216 10 6273</b>				
17. INFORMANT <b>FRANK B. NELSON</b>					18. ADDRESS <b>1715 MORELAND AVE</b>									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> <b>Hypertension</b>										INTERVAL BETWEEN ONSET AND DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <b>0 -</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>					20A. AUTOPSY? (Yes or No) <b>NO</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>-</b>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>-</b>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? <b>-</b>				
22. I certify that (I) (this hospital) attended the deceased from <b>11-30</b> 19 <b>66</b> to <b>12-2</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-2</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Lucas C. Vidhyaphum</b>										23B. DATE SIGNED				
23C. PHYSICIAN'S NAME (Type) <b>LUCAS C. VIDHYAPHUM</b>										23D. ADDRESS <b>Lutheran Hospital of Maryland</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>12/6/66</b>					24C. NAME OF CEMETERY or CREMATORY <b>Arbutus mem. Pk</b>				
24D. LOCATION (City, town, or county) (State) <b>Arbutus Md</b>					25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>					25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>				
25C. FUNERAL DIRECTOR <b>Joseph B. Locks</b>					25D. ADDRESS <b>1304 N. Central</b>									

*[Faint, illegible text and markings on a form, likely a Certificate of Death. The form contains various fields and lines for data entry, but the content is too faded to transcribe accurately.]*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 12132		CERTIFICATE OF DEATH		Registered No. 66 12132	
1. NAME OF DECEASED (Type or Print) <i>Vincent Gorman</i>				2. DATE AND HOUR OF DEATH <i>Dec. 2, 1966</i> <i>6 P. M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>8-01</i> <i>3111 Belair Road</i>					
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>April 2, 1900</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Employee American Oil Co.</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW I</i>			16. SOCIAL SECURITY NO. <i>220052200A</i>		17. INFORMANT <i>May W. Gorman</i>		ADDRESS <i>same</i>		
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Coronary Thrombosis</i> DUE TO (B) <i>Arteriosclerosis C.V.D.</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 da</i> <i>10 yrs</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____					
22. I certify that (I) (this hospital) attended the deceased from <i>19 56</i> to <i>November</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>11-30</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>J. Duer Moores</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>12-3-66</i>					
23C. PHYSICIAN'S NAME (Type) <i>J. DUEVER MOORES</i>				23D. ADDRESS <i>3105 BELAIR RD 21213</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>12-6-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore Nat'l Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>1166 R. E. P. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc</i>		ADDRESS <i>Baltimore, Md.</i>			

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1. DUBER MIREAS  
H. DUBER MIREAS

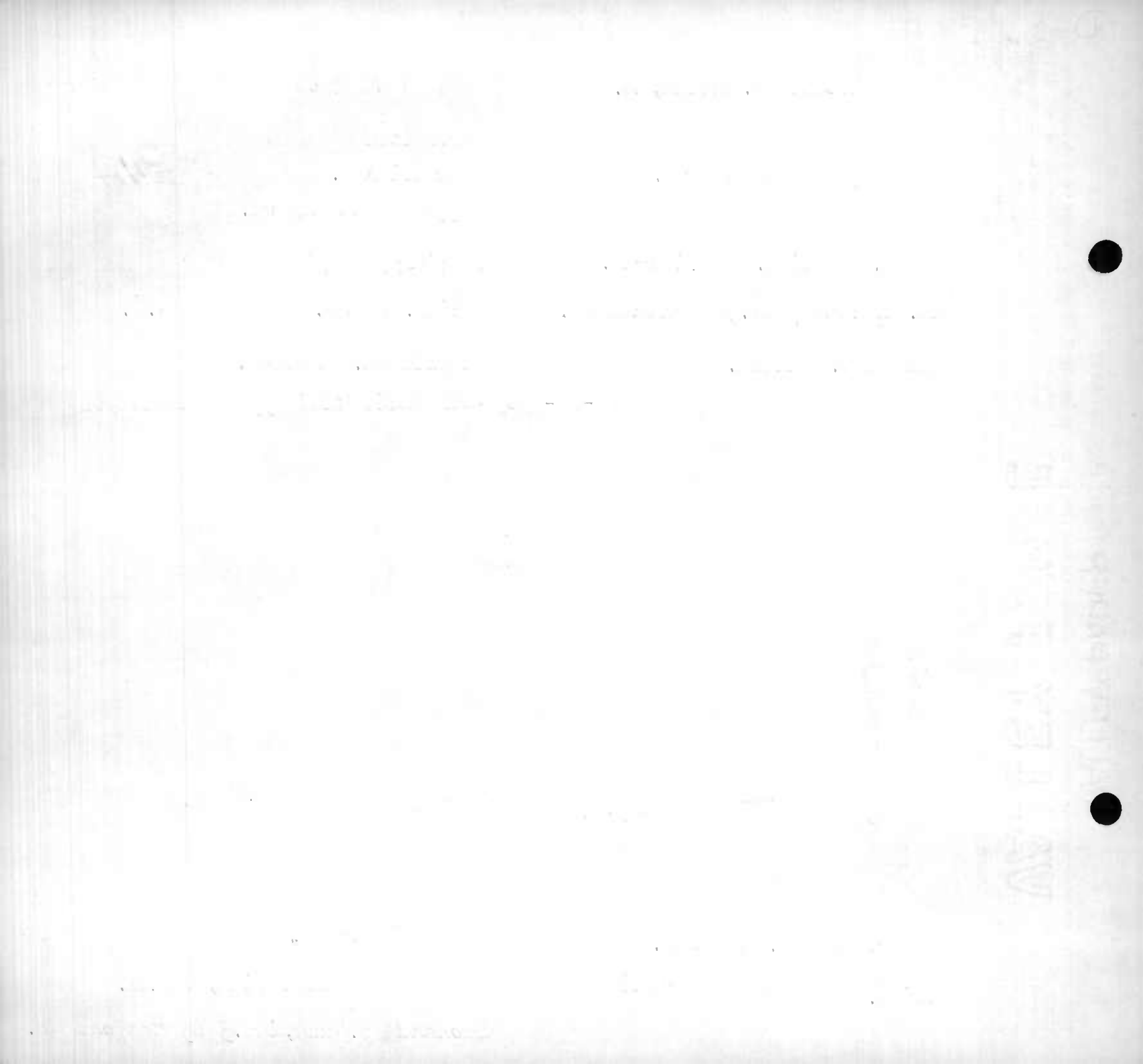
THE BEAIR RD

11-25 10 25

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12133				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12133		
M.E. CASE NO.				CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>Walter M. Duncan, Sr.</i>				2. DATE AND HOUR OF DEATH <i>12/2/66 2:35 P. M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore.</i>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>5501 Carter Ave.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-44</i>				
D. STREET ADDRESS (If rural, give location) <i>5501 Carter Ave.</i>								
5. SEX <i>Male.</i>	6. RACE <i>White.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widower.</i>	8. DATE OF BIRTH <i>4/10/1894</i>	9. AGE (In years lost birthday) <i>72</i>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ins. Adjuster (Ret.)</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Insurance.</i>		11. BIRTHPLACE (State or foreign country) <i>Phila. Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Hayes H. Duncan.</i>				14. MOTHER'S MAIDEN NAME <i>Sadie K. Peters.</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-01-3585</i>		17. INFORMANT ADDRESS <i>Mrs Doris Hirt 5501 Carter Ave</i>		
18. <i>181.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Carcinoma of bladder</i> DUE TO <i>with pelvic metastasis</i> (B) <i>Arteriosclerosis Cardiovascular</i> (C) <i>Chronic myocarditis</i> <i>18 years</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 years</i>
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>May 1949</i> to <i>Dec. 2 1966</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Nov. 30 1966</i> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.								
23A. SIGNATURE <i>H. V. Harbold</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Dec. 2, 1966</i>		
23C. PHYSICIAN'S NAME (Type) <i>Harold V. Harbold.</i>				23D. ADDRESS M.D. <i>4706 Harford Road Baltimore Maryland</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/6/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Arlington</i>		24D. LOCATION (City, town, or county) <i>Drexel Hill, Penna.</i>		
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR <i>Donald J. Ruck, inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>5305 Harford Rd.</i>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 12134					Registered No. 66 12134				
CERTIFICATE OF DEATH									
BIRTH NO. 66 12134					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>KESTNER, ELSIE MAY</i>					2. DATE AND HOUR OF DEATH <i>12-3-66 3:55 A. M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE UNION MEMORIAL HOSPITAL</i>					A. STATE <i>MARYLAND</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE #14</i>				
44					D. STREET ADDRESS (If rural, give location) <i>2905 HALLEYON AVE</i>				
5. SEX <i>F</i>	6. RACE <i>CAU</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>3-17-93</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookbinder</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Bookbinder</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>OLIVER DAVID LUAREHEIM</i>					14. MOTHER'S MAIDEN NAME <i>MARY ELIZABETH REIFSNIDER</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>213-000-3810 A</i>		17. INFORMANT <i>Mrs. Angela Franco</i>			ADDRESS <i>5511 ALGIRIM RD, BALT, MD.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.0 I</i>					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <i>3</i>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO <i>PULMONARY EDEMA</i>				
ANTECEDENT CAUSES					(B) DUE TO <i>CONGESTIVE HEART FAILURE</i>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) <i>ASHD</i>				
II					NONE				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>NONE</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NONE</i>		20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>No</i>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NONE</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>NONE</i>				
21D. TIME OF INJURY (APPROX.) <i>NONE</i>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW OLD INJURY OCCURRED? <i>NONE</i>				
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>11-29-66</i> to <i>12-3-66</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>12-2-</i> <i>19 66</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <i>Jeff Parker</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>12-3-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>JEFF PARKER</i>					23D. ADDRESS <i>THE UNION MEMORIAL HOSP, BALT., MD.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/6/66.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Olivet Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 5 1966</i>		25B. NAME OF REGISTRAR <i>2025 E. Baltimore</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>			ADDRESS <i>Balto. Md. 21214</i>		

Jeff Baker  
John Baker

The Union Movement for Peace

12-7-41

12-2-

11-24

11-24

11-24

None

None

None

None

A240

Constitution for Peace

Peace for Peace

None

No

Constitution for Peace

Peace for Peace

Constitution for Peace

Peace for Peace

Constitution for Peace

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Peace for Peace

B-460 66 12135

BALTIMORE CITY HEALTH DEPARTMENT

66 12135

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CAROLINE A.

BUEHLER

2. DATE AND HOUR PRONOUNCED DEAD

12-3-66

14:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2816 Guilford Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2816 Guilford Ave.

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 26, 1912

9. AGE (In years  
lost birth day)

54 83

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Personel Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

State Of Md.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Buehler

14. MOTHER'S MAIDEN NAME

Anna Voegtlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Louis F. Buehler 2816 Guilford Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cirrhosis of liver

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-3-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/5/66

23C. NAME of CEMETERY or CREMATORY

Jerusalem

23D. LOCATION (City, town, or county) (State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Leonard J Ruck Inc 5305 Harford Rd.

WILLY WATSON

WILLIE PROCTOR

1935 now collector



C-514

66 12136

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12136

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>WINETTA</b> <del>WINETTA KENNEDY</del> <b>F. CAMPBELL</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>12-2-66</b> <b>8:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2832 Mayfield Ave.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2832 Mayfield Ave.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>December 2, 1903.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>	9. AGE (In years last birthday) <b>62 63</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas B. Fowler, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-2361</b>	
17. INFORMANT <b>Mrs. Edith L. Schulz,</b>		ADDRESS <b>4223 Soth Ave. #36</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-3-66</b>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>12/6/66.</b>	
23C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
24C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>	

RECEIVED

VALLEY FORCE

1  
E-263

66 12137

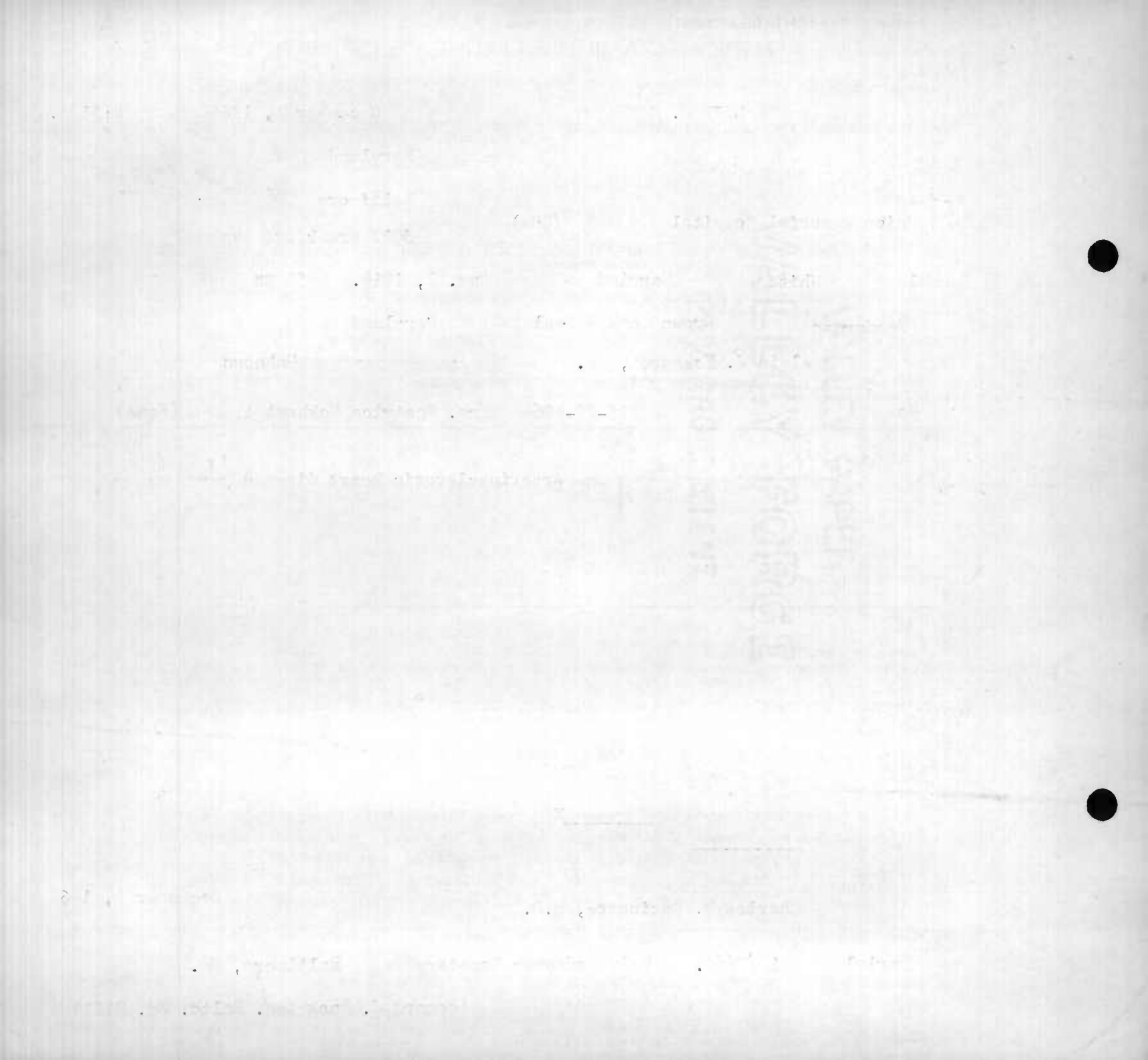
BALTIMORE CITY HEALTH DEPARTMENT

66 12137

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
ALVIN J. ECKHARDT		December 4, 1966 2:51 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 99 Union Memorial Hospital (DOA)		A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore #6 26-08	
		D. STREET ADDRESS (If rural, give location)	
		5013 Frankford Avenue	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	White	Married	Aug. 2, 1914.
9. AGE (In years last birthday)		10. BIRTHPLACE (State or foreign country)	
52 38		Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Feederman		Crown Cork & Seal	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Alvin J. Eckhardt, Sr.		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		215-09-4964	
17. INFORMANT		ADDRESS	
Mrs. Beatrice Eckhardt		(Same)	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
(A) Arteriosclerotic heart disease DUE TO			
(B) DUE TO			
(C) DUE TO			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED	
		December 4, 1966	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/7/66.	Holy Redeemer Cemetery	Baltimore, Md.
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1966	Charles S. Springate, M.D.	Leonard J. Ruck Inc. Balto. Md.	21214

MEDICAL CERTIFICATION



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 12138	
BIRTH NO. 66 12138		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Carroll Jasper						2. DATE AND HOUR OF DEATH		Dec. 3, 1966 8: 10 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE B. COUNTY					
U S Public Health Service Hospital Wyman Pk. Drive & 31st Street						Maryland					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)						Baltimore #14 87-02					
D. STREET ADDRESS (If rural, give location)						2804 E. Coldspring Lane					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 5/1/41		9. AGE (in years last birthday) 25		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Recreation Director				10B. KIND OF BUSINESS OR INDUSTRY Balto. County School				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E. William Jasper, Jr.						14. MOTHER'S MAIDEN NAME Violet Ayd					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USMC 1961- 2 wks.				16. SOCIAL SECURITY NO. 213-38-9175		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.					
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										(A) DUE TO atelectasis Right lung days	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										(B) DUE TO Pleural effusions days	
ANTECEDENT CAUSES										(C) DUE TO Hodgkins disease involving multiple nodes + organs months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										None	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Dec. 2 19 66 to Dec. 3 19 66, that (I) (we) lost saw the deceased alive on Dec. 3 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Thomas Lau M.D.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3 Dec 66	
23C. PHYSICIAN'S NAME (Type) THOMAS LAU				23D. ADDRESS M.D. US PHS Hospital, Balto, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/66.		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214			

DEC 5 1966

Reuben E. F. J. J. J.

Leonard J. Ruck, Inc. Balto. Md. 21214

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12139		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12139	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WHITE, JULIA ANN		2. DATE AND HOUR OF DEATH 11-30-66 2:55 AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL		A. STATE Md B. COUNTY Balt City			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt 13-02			
		D. STREET ADDRESS (If rural, give location) 2241 Eutan Place			
5. SEX Female	6. RACE N	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 7-1-28	9. AGE (In years last birthday) 36	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME UNK		14. MOTHER'S MAIDEN NAME UNK		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNK		17. INFORMANT DT	
18. 330X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ? CVA (A) C DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Possible berryaneurysm (C) Cardiac arrest				X3	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia & pneumothorax					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-29 1966 to 11-30 1966, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE PP Toskes		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/1/66	
23C. PHYSICIAN'S NAME (Type) PP. Toskes		23D. ADDRESS M.D. PT Lawrence			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary	
24D. LOCATION Brooklyn Md					
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1966		25B. NAME OF REGISTRAR Robert E. Galt		25C. FUNERAL DIRECTOR Charles A. Rice	
				ADDRESS 661 W. Baltimore	

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12140</u>	
BIRTH NO. <u>66 12140</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Kensington White</u>		2. DATE AND HOUR OF DEATH <u>December 3, 1966</u> <u>7:00</u> a. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Provident Hospital, Inc.</u> <u>1514 Division St.</u> <u>Baltimore, Maryland 21217</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1319 Myrtle Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8-11-21</u>	9. AGE (In years) last birthday <u>45</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-14-7201</u>	17. INFORMANT ADDRESS <u>Lillian White 1319 Myrtle Ave</u>		
18. <u>581.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cirrhosis of Liver</u> DUE TO (B) <u>Ascaris</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-2-66</u> 19 to <u>12-3-66</u> 19, that (I) (we) last saw the deceased alive on <u>12-3-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> 23C. PHYSICIAN'S NAME (Type) <u>Dr. C. Laredo</u>				23B. DATE SIGNED <u>12-3-66</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/7/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>mt Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1966</u>			
25B. NAME OF REGISTRAR <u>Charles E. Fadden</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles E. Rice 661 W. Borne St</u>			

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## FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

66 12141

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

2. DATE AND HOUR OF DEATH

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

(If rural, give location)

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give year or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.11

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A)

Myocardial Infarction

DUE TO

1/2 hour

(B)

Hypertensive cardiovascular dis.

DUE TO

6 years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10 19 60 to 12 1 19 66,  
that (I) (we) last saw the deceased alive on DOA 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S  
NAME (Type)

M.D.

23D. ADDRESS

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

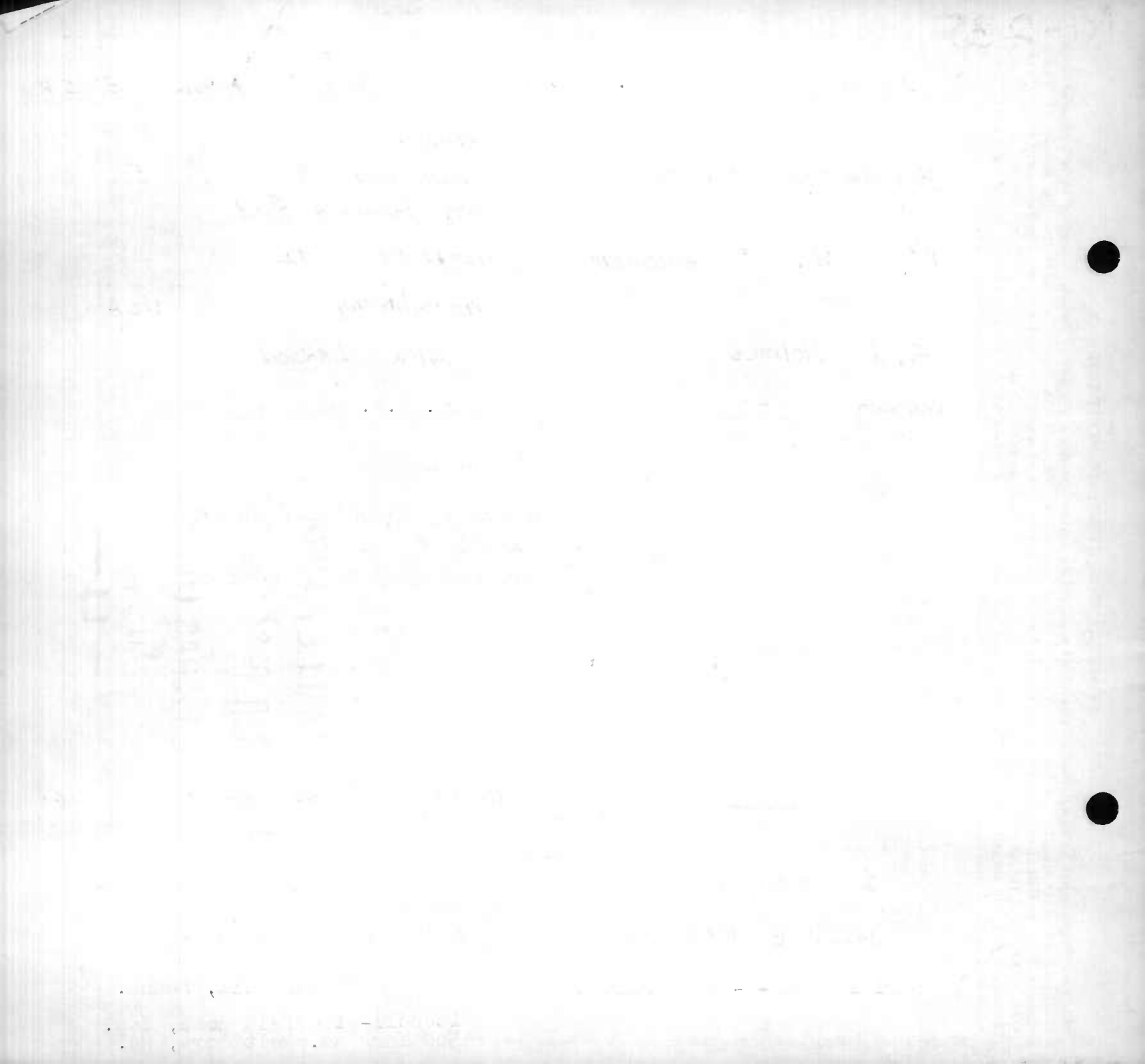
2. 1894-1895

Charles & John  
1894-1895

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12142	
CERTIFICATE OF DEATH					
BIRTH NO. 66 12142		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Mrs. Myra Maston</i> Myra B. Maston		2. DATE AND HOUR OF DEATH <i>December 4, 1966</i> 3:05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co.</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 7</i>			
34		D. STREET ADDRESS (If rural, give location) <i>1189 Granville Road</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>12-22-93</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Fred Holmes</i>			14. MOTHER'S MAIDEN NAME <i>Julia LARSON</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. K.B. Edmunds</i>		ADDRESS <i>Same</i>
18. <i>370.31</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Toxemia</i> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>massive small and large bowel gangrene</i> DUE TO			
		(C) <i>mesenteric artery thrombosis</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initial medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <i>this hospital</i> ) attended the deceased from <i>11-27</i> 19 <i>66</i> to <i>12-4</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12-4-</i> 19 <i>66</i> and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <i>did</i> ) ( <i>did not</i> ) view the body after death.					
23A. SIGNATURE <i>George B. Joaquina</i>				23B. DATE SIGNED <i>12-4-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>GEORGE B. JOAQUINO</i>		23D. ADDRESS <i>BON SECOURS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-7-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Arlington</i>	
24D. LOCATION (City, town, or county) (State) <i>Drexel Hill, Penna.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 5 1966</i>		25B. NAME OF REGISTRAR <i>ALICE E. F. D. J.</i>		25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home, Inc.</i>	
				ADDRESS <i>6500 York Rd. Baltimore, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 12143					Registered No. 66 12143				
CERTIFICATE OF DEATH									
BIRTH NO. 66 12143					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Ethel Dunton</u>					2. DATE AND HOUR OF DEATH <u>11-30-66</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u>					A. STATE <u>Md.</u> B. COUNTY				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
					D. STREET ADDRESS (If rural, give location) <u>1026 Ellicott Drive</u>				
5. SEX <u>Female</u>	6. RACE <u>Negroid</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10-20-11</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Dunkins</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Beckett</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>George Dunton 1026 Ellicott Drive</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.11</u> <u>Cranium Insufficiency</u> <u>HACVD</u>					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>Years</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Acute viral infection of bronchial passages</u>					<u>4 days</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
<u>0</u>									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>about 1957</u> 19 to <u>11/30/</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/28/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Lucius W. Leeper</u> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>12/5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lucius W. Leeper</u>					23D. ADDRESS <u>1200 Blumington Rd.</u> M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>12-5-66</u>		<u>Mt. Auburn Cemetery</u>		<u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<u>DEC 5 1966</u>		<u>George E. Nelson</u>		<u>George E. Nelson</u>		<u>1348 N. Calhoun St.</u>			

Handwritten text, possibly a signature or name, located in the upper left quadrant.

Handwritten text, possibly a signature or name, located in the center of the page.

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Handwritten text, possibly a signature or name, located in the lower right quadrant.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12144				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12144	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HAYNES, SAMUEL NMI</b>				2. DATE AND HOUR OF DEATH <b>November 30, 1966</b>		<b>12: 25 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>Philadelphia</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>V-35</b> D. STREET ADDRESS (If rural, give location) <b>805 E Passayunk Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1/17/33</b>	9. AGE (In years lost birthday) <b>33</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garrage Man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Garrage</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Forrest Haynes</b>				14. MOTHER'S MAIDEN NAME <b>Laveda Taylor</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 2/19/53 - 1/28/55</b>		16. SOCIAL SECURITY NO. <b>180-26-44-21</b>		17. INFORMANT <b>Records</b>		ADDRESS <b>VAH Baltimore, Maryland 21218</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Hemoptysis</b> DUE TO <b>Probable bronchogenic Carcinoma</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>3 months</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>O</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>he</b> (this hospital) attended the deceased from <b>November 28</b> 19 <b>66</b> to <b>November 30</b> 19 <b>66</b> , that <b>he</b> (we) lost saw the deceased alive on <b>November 30</b> 19 <b>66</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the cause stated above. <b>he</b> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>David N. Marine</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/1/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>David N. Marine</b>				23D. ADDRESS <b>Veterans Administration Hospital 3900 Loch Raven Blvd 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>Dec 3/66</b>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Philadelphia Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Milton E. Elickson</i>		ADDRESS <i>1129 N. Chestnut St</i>	

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66 12145

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12145

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EUGENE SMITH

2. DATE AND HOUR PRONOUNCED DEAD

November 27, 1966 11:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)33  
99 Johns Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 5-01

D. STREET ADDRESS (If rural, give location)

1400 E. Baltimore Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

July 8 1917

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Na

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War #2

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred Dickerson 5 N. Caroline St

18. 443 X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Hypertensive and arteriosclerotic  
cardiovascular diseaseINTERVAL BETWEEN  
ONSET AND DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 28, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 5 1966

Robert E. Taylor

Milton E. Edickson 1129 N. Caroline St

July 8 1911

Sample

Unimproved  
land

for road work

unimproved

Michigan Highway 5

Michigan Highway 5

Sample for 1/2 mile  
Michigan Highway 5

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARY

GRADY

2. DATE AND HOUR PRONOUNCED DEAD

November 30, 1966

12:30 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

716 N. Payson Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

716 N. Payson Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 8, 1913

9. AGE (In years  
last birthday)

43

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James L. Rawson

14. MOTHER'S MAIDEN NAME

Therrie A. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

William L. Grady

18.

345 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Acute Disseminated Sclerosis.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, lorn, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/30/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

James H. Brown  
March 10, 1893  
New York, N.Y.

My dear Sir

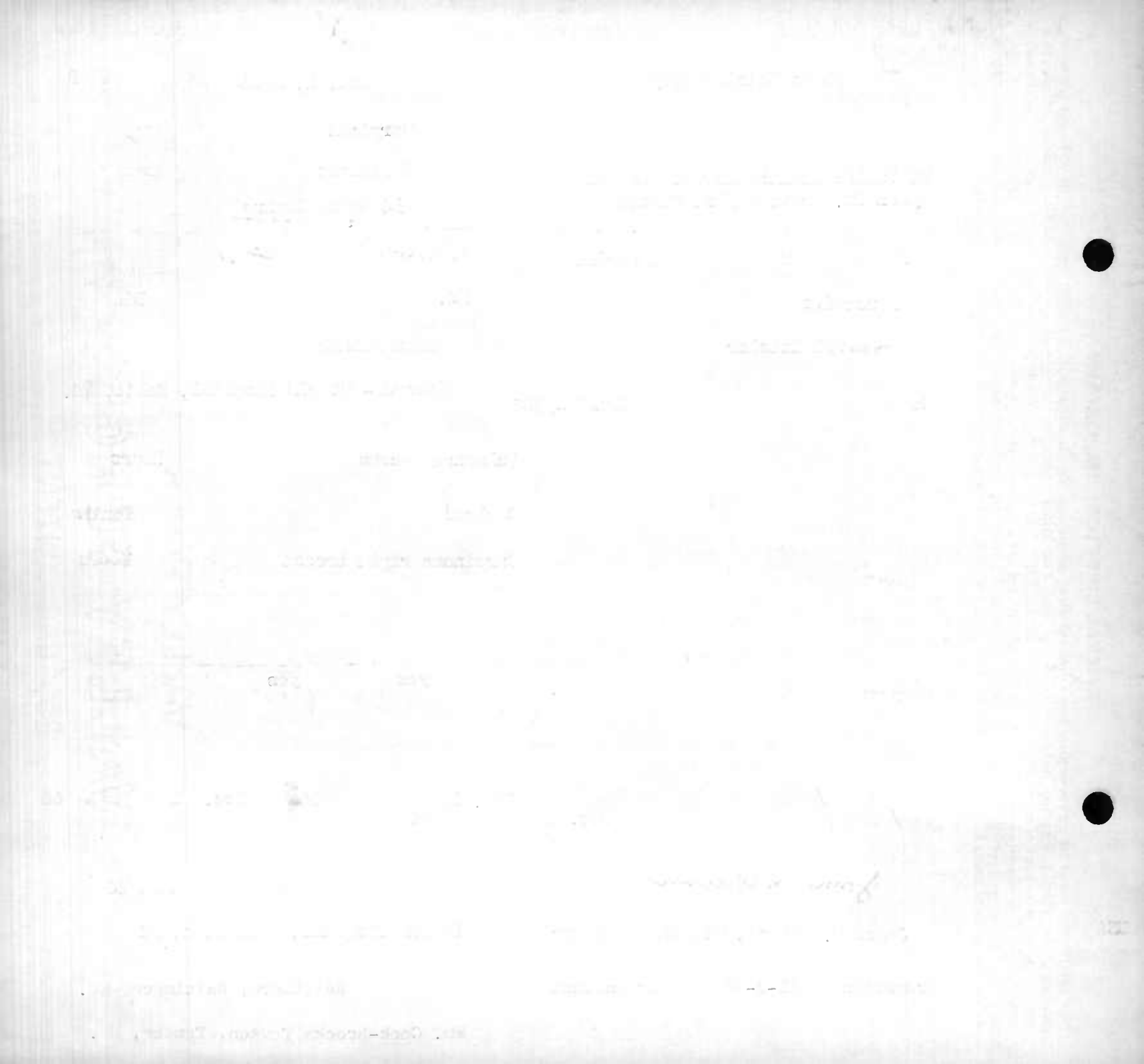
Thank you for the  
information received

Yours very truly  
James H. Brown

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Baltimore City Health Department	
BIRTH NO. 66 12147		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 12147	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Rhoda Boteler Doty			2. DATE AND HOUR OF DEATH Dec. 1, 1966 8 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8 US Public Health Service Hospital Wyman Pk. Drive & 31st Street			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balt. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 34 Cedar Avenue		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/17/05	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Emanuel Boteler			14. MOTHER'S MAIDEN NAME Emma Rohner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-3362	17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema & Cachexia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma right breast			INTERVAL BETWEEN ONSET AND DEATH Hours Months Years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Oct. 17 1966 to Dec. 1 1966, that (1) (we) last saw the deceased alive on Dec. 1 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James M. Weaver M.D.				23B. DATE SIGNED 12/2/66	
23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director M.D.			23D. ADDRESS US PHS Hospital, Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 12-3-66	24C. NAME of CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Baltimore, Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1966		25B. NAME OF REGISTRAR Wm. Cook-Brooks		25C. FUNERAL DIRECTOR ADDRESS Towson, Md.	

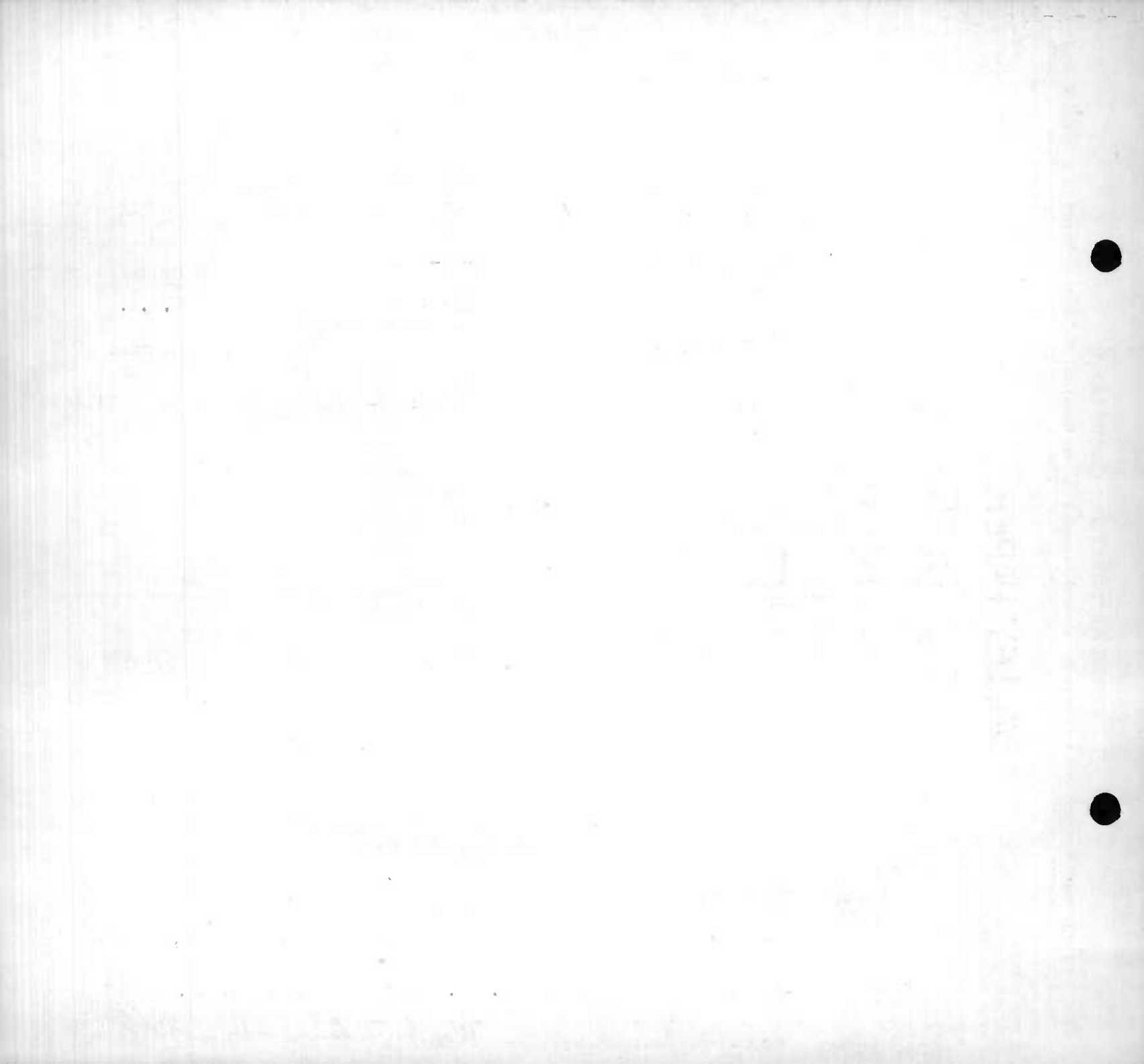




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

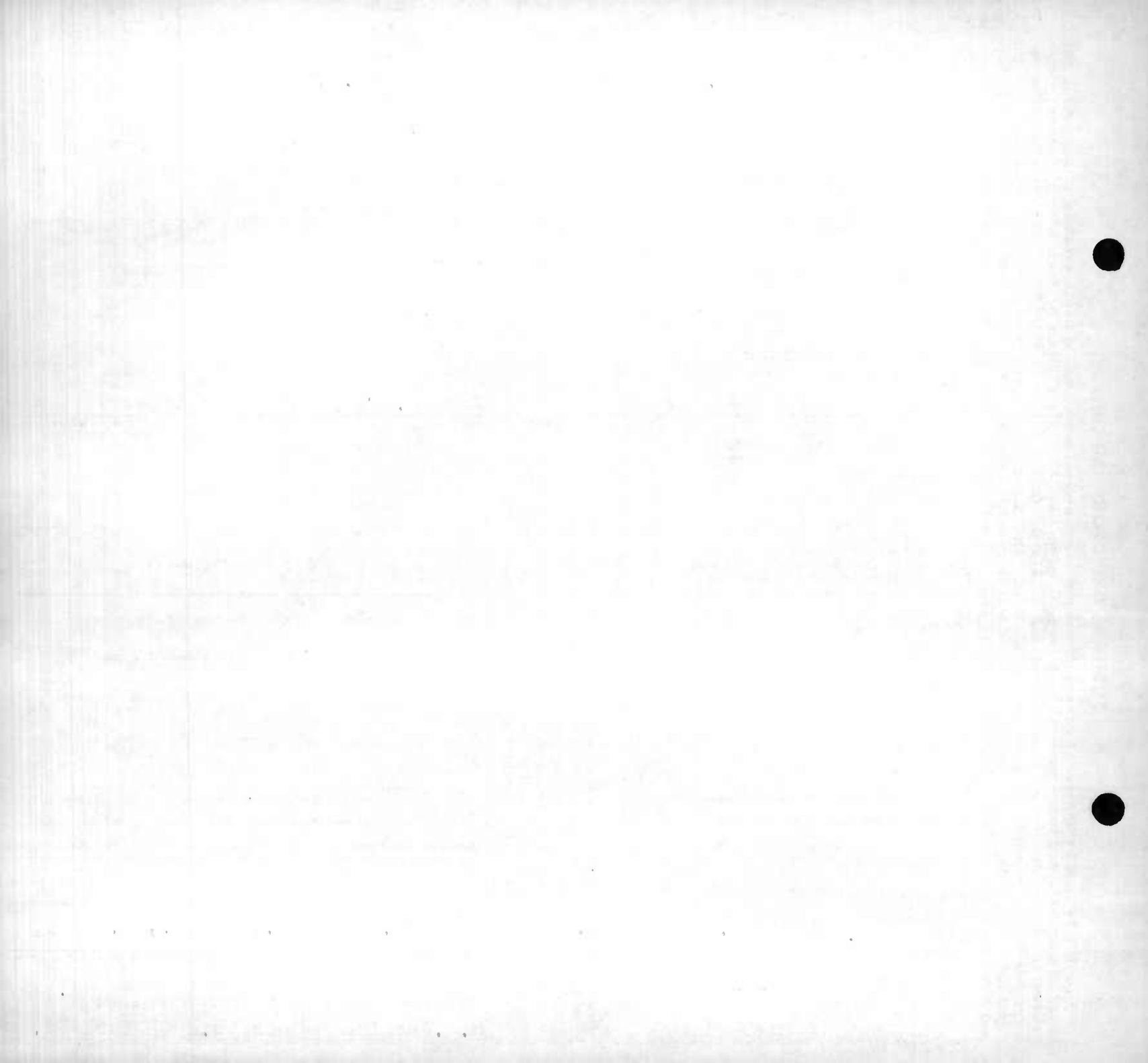
BIRTH NO. 66 12148		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12148	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Ellen Kohlhepp</u>		2. DATE AND HOUR OF DEATH <u>12-4-66</u> <u>3:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Eastpoint</u> <u>53-00</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		D. STREET ADDRESS (If rural, give location) <u>7915 Lansdale Road</u> <u>21224</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>6-23-1911</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Brookman</u>		14. MOTHER'S MAIDEN NAME <u>Kate Dennerman</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue</u> <u>21224</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Acute myocardial infarct</u> DUE TO (B) <u>Coronary artery disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u> <u>5 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-4-1966</u> to <u>12-4-1966</u> , that (I) (we) last saw the deceased alive on <u>12-4-1966</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ross Krueger</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-4-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ross Krueger</u>		23D. ADDRESS M.D. <u>4940 Eastern Avenue, Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/7/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Mem. Pk. Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Wm. J. Tiskner</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Tiskner</u>	
25D. ADDRESS <u>Wm. J. Tiskner</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

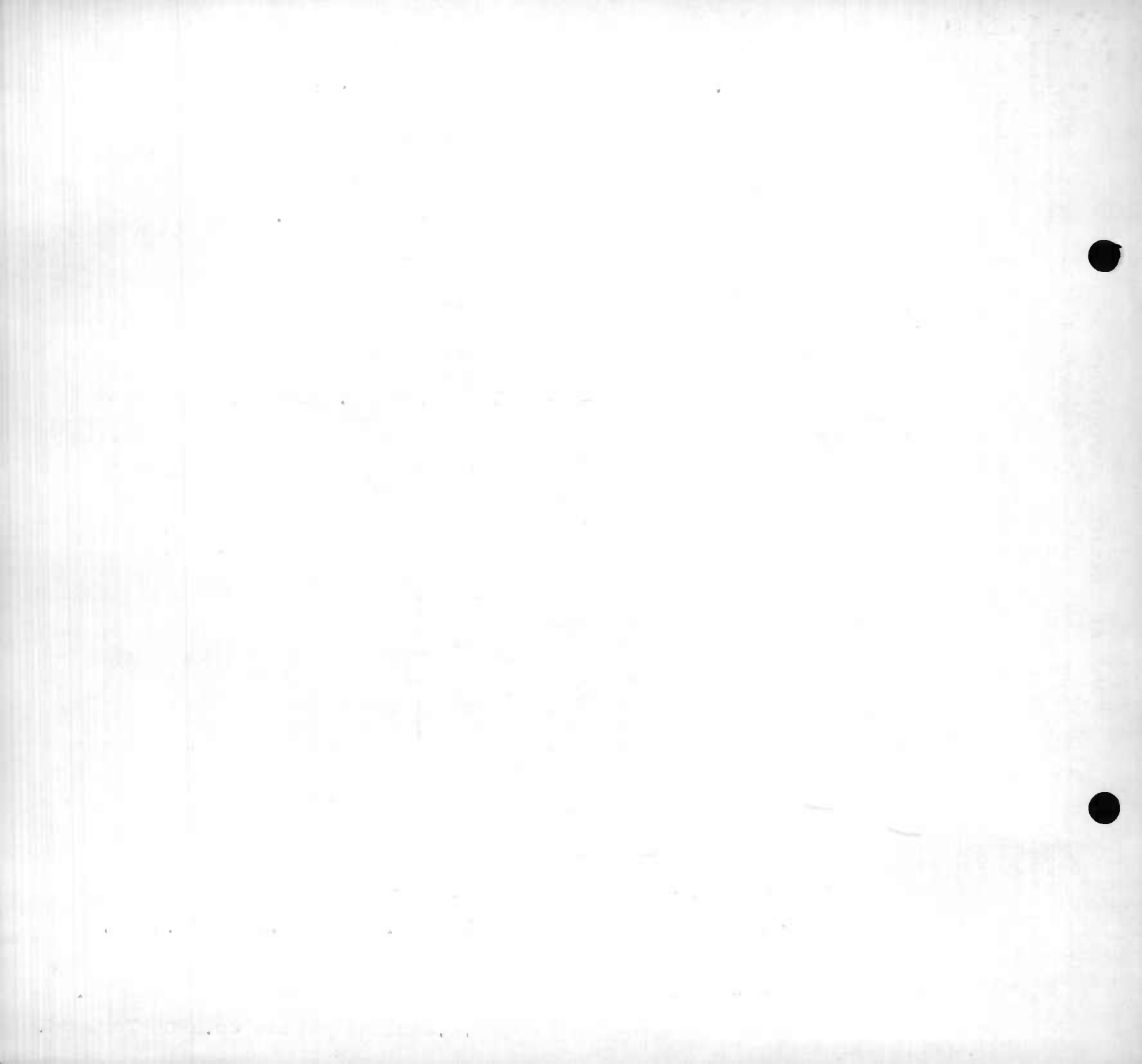
Baltimore City Health Department				Registered No. 66 12149	
Certificate of Death					
BIRTH NO. 66 12149					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Alice V. Flanigan		Dec. 2, 1966		7 <sup>00</sup> P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)		Maryland			
00 4308 Greenway		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		4308 Greenway			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	W	Married	3-19-1897	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Karsner			Molly Miskimmon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				John A. Flanigan Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		6 mos.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work			
22. I certify that (I) (this hospital) attended the deceased from August 9 1966 to Dec 2 1966, that (I) (we) lost saw the deceased alive on December 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Alfred G. Ossman Jr. M.D.				12-5-66.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Alfred G. Ossman Jr. M.D.		1010 St. Paul St., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12-5-66		Woodlawn	
				Woodlawn Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 5 1966		H. W. Jenkins & Sons Co.		4905 York Rd.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

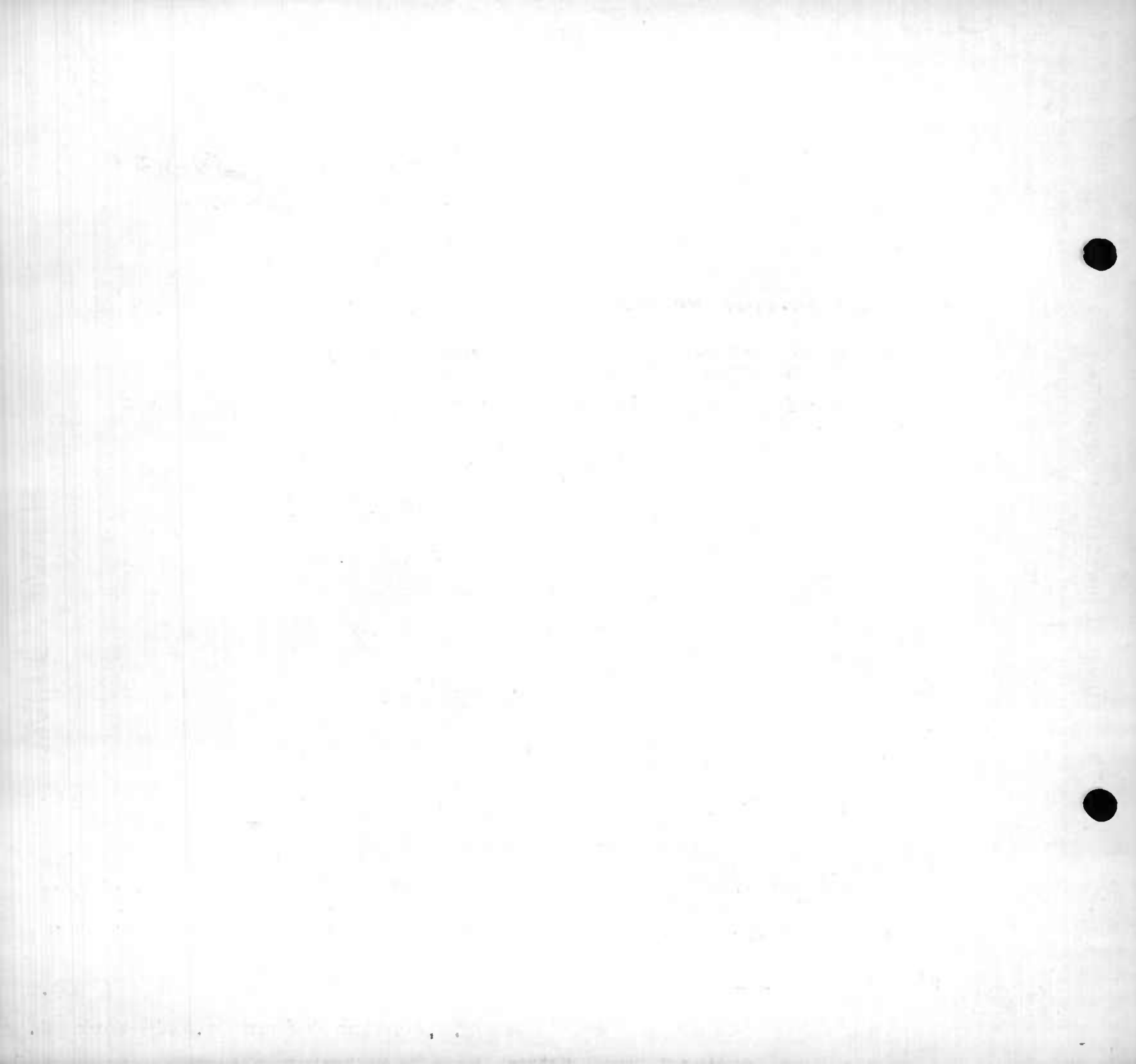
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12150</u>	
<div style="display: flex; justify-content: space-between;"> <span>IRTH NO. <u>66 12150</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <u>Frank J. Panuska</u>			<b>2. DATE AND HOUR OF DEATH</b> <u>Dec. 3, 1966</u> <u>11:25 A.M.</u>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00 3802 Kimble Road</u>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>9-01</u> D. STREET ADDRESS (If rural, give location) <u>3802 Kimble Rd.</u>		
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>10-29-1897</u>	<b>9. AGE</b> (In years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Industrial Plant</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>Joseph Panuska</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Bartok</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>273-07-1331</u>	<b>17. INFORMANT</b> <u>Lillian M. Panuska</u>		<b>ADDRESS</b> <u>Above</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>163 X I</u> <b>CAUSE OF DEATH</b> (A) <u>Carcinoma of lung</u> DUE TO (B) _____ DUE TO (C) _____ <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>14 months</u>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>No</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <u>9/14</u> <u>1966</u> to <u>12/3</u> <u>1966</u>, that (I) (we) last saw the deceased alive on <u>11/19</u> <u>1966</u> and that in (my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Dr. F. Cox</u>				<b>23B. DATE SIGNED</b> <u>5 Dec 66</u>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <u>Frank Cox III</u>				<b>23D. ADDRESS</b> <u>1118 St. Paul St., Balto., Md.</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>12-6-66</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Belair Memorial</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Belair Md.</u>					
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b> <u>H.W. Jenkins &amp; Sons Co.</u>	
				<b>ADDRESS</b> <u>4905 York Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12151</b>	
BIRTH NO. <b>66 12151</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Mr Austin R. Crook</b>		2. DATE AND HOUR OF DEATH <b>Dec 3 1966</b> <span style="float: right;"><b>6 15 A M.</b></span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3633 Greenmount Ave</b>		A. STATE <b>Maryland</b> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 9-03</b>			
		D. STREET ADDRESS (If rural, give location) <b>3633 Greenmount Ave.</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married.</b>	8. DATE OF BIRTH <b>4/14/97</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employment Secretary</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Md. State</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James W. Crook</b>		14. MOTHER'S MAIDEN NAME <b>Ann Cawley</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.I</b>		16. SOCIAL SECURITY NO. <b>220-10-2020</b>		17. INFORMANT <b>Augusta F. Crook</b>	
				ADDRESS <b>Above</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Ischemia</b>		CAUSE OF DEATH (A) DUE TO <b>Coronary Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>plus Bronchopneumonia.</b>		<b>years.</b>	
		(C) <b>Renal Insufficiency.</b>		<b>several days.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (This hospital) attended the deceased from <b>July 4, 1965</b> to <b>Dec 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 3, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lester A. Wall Jr</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Dec 3 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>LESTER A. WALL JR</b>		23D. ADDRESS M.D. <b>1039 ST. Paul ST, Baltimore Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-6-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>			
25B. NAME OF REGISTRAR <b>H.W. Jenkins &amp; Sons Co.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4905 York Rd.</b>			





66 12152

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12152

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ALDO

C.

FRATTINI

2. DATE AND HOUR PRONOUNCED DEAD

December 2, 1966

4:20 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1034 Evesham Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1-7-1914

9. AGE (In years  
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Civil Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Gov't.

11. BIRTHPLACE (State or foreign country)

Vermont

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Martin Frattini

14. MOTHER'S MAIDEN NAME

Elisa Gargantini

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

115-12-4999

17. INFORMANT

Frances A. Frattini

ADDRESS

Above

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/2/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Entombment

23B. DATE

1-5-1966

23C. NAME of CEMETERY or CREMATORY

Lorraine Mausoleum

23D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

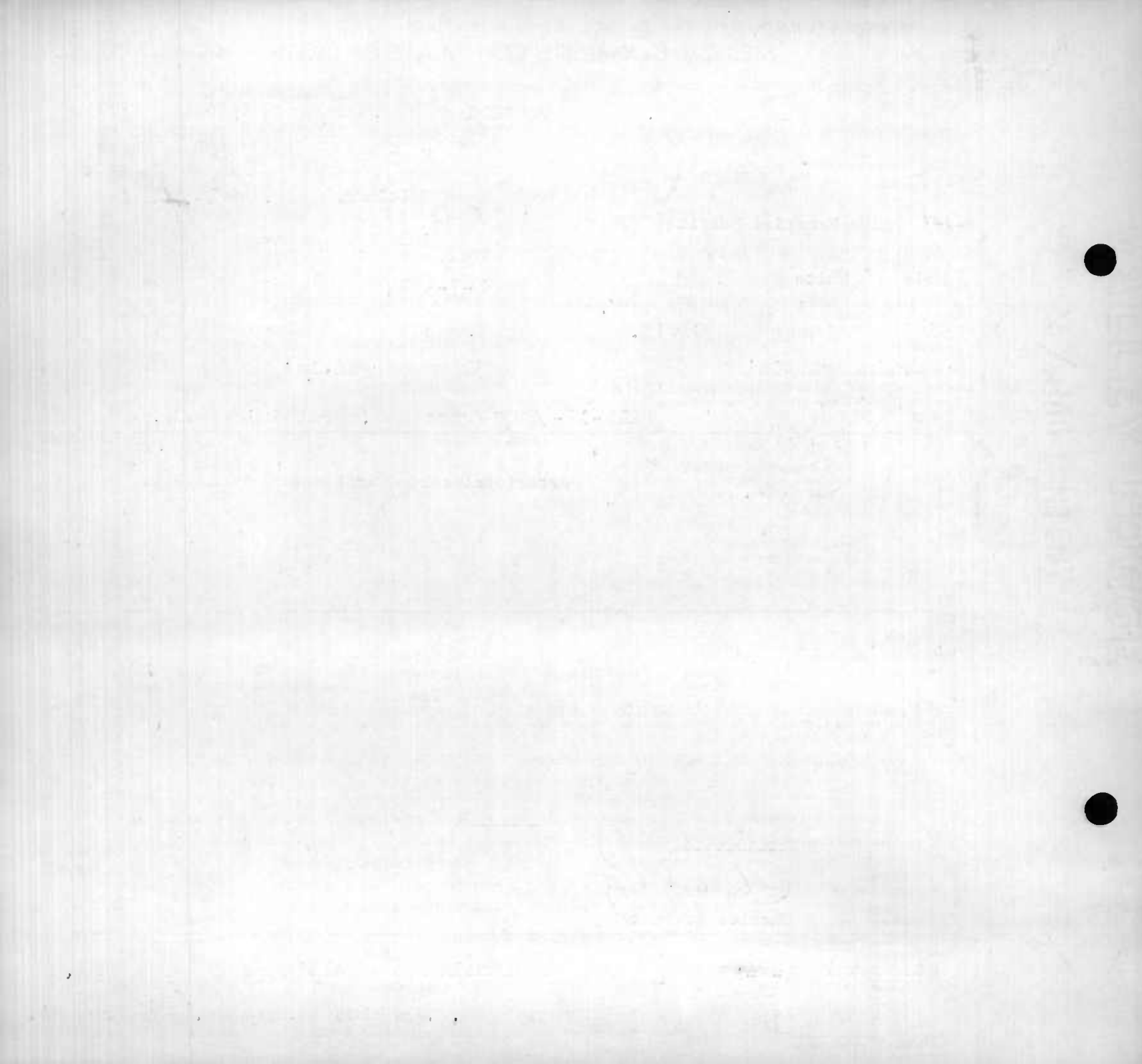
24C. FUNERAL DIRECTOR

ADDRESS

DEC 5 1966

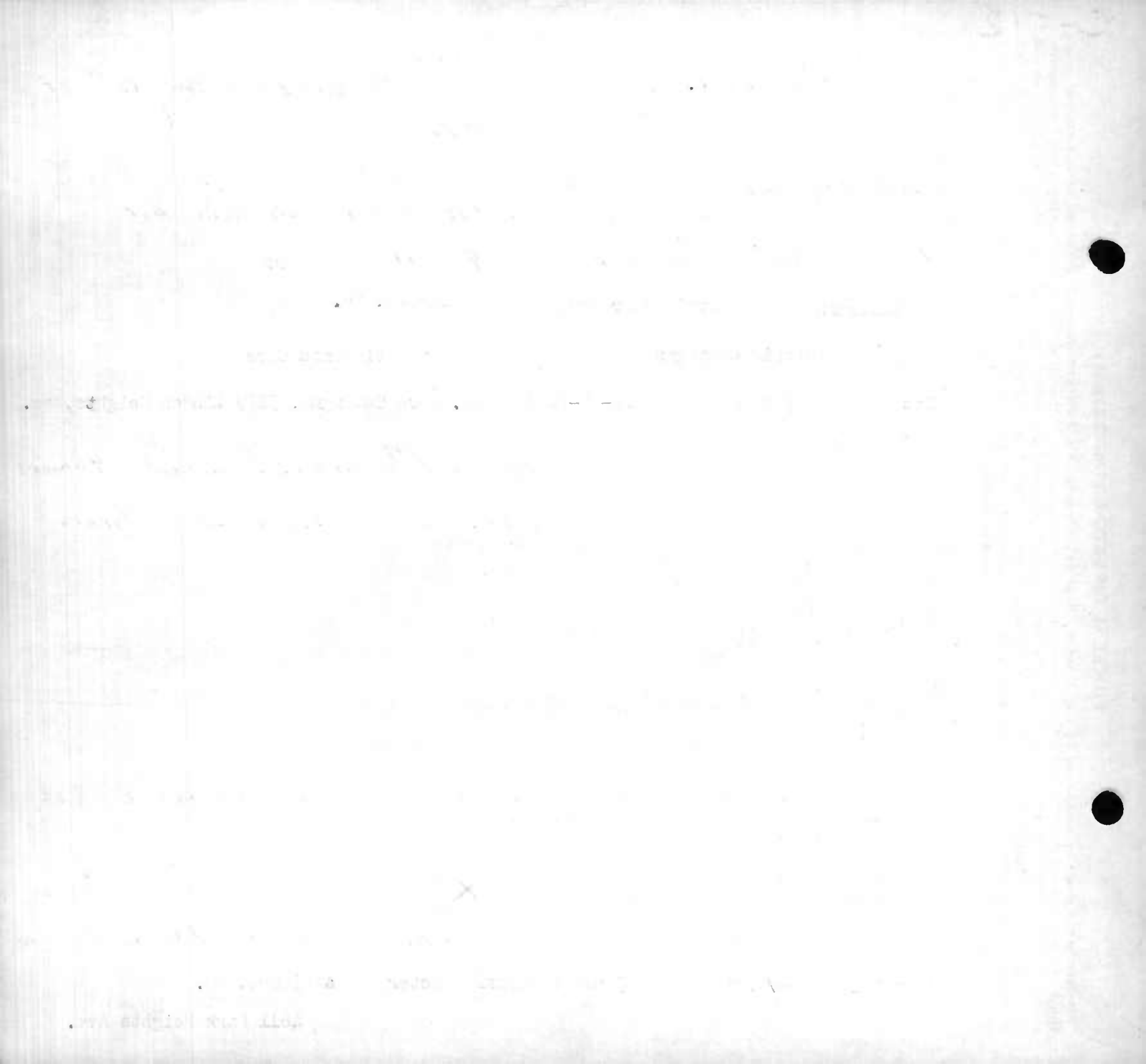
R. L. E. F. J. M. D.

H. W. Jenkins &amp; Sons Co. 4905 York Rd.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 12153</u>	
BIRTH NO. <u>66 12153</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>CASPER J. Campagna</u>		2. DATE AND HOUR OF DEATH <u>December 3, 1966 12<sup>30</sup> P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL, BALTIMORE, MD.</u> <u>42</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>		B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		D. STREET ADDRESS (If rural, give location) <u>5119 LINDEN HEIGHTS AVE.</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	B. DATE OF BIRTH <u>9-3-11</u>	9. AGE (In years last birthday) <u>55</u>	11. Under 1 Yr. Months Days		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Fruit &amp; Produce</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Antonio Campagna</u>				14. MOTHER'S MAIDEN NAME <u>Vincenza Cire</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W # 2</u>		16. SOCIAL SECURITY NO. <u>216-07-7176</u>		17. INFORMANT <u>Mrs. Rose Campagna, 5119 Linden Heights, Ave.</u>		ADDRESS	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>7 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>DECEMBER 3</u> 19 <u>66</u> to <u>DECEMBER 3</u> 19 <u>66</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>DECEMBER 3</u> 19 <u>66</u> and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <u>Howard H. Gendason</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>December 3, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>HOWARD H. GENDASON</u>				23D. ADDRESS <u>11969 REISTERSTOWN RD. REISTERSTOWN MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/7/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>W. Vernon Gendason</u>		ADDRESS <u>4611 Park Heights Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12154					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 12154				
1. NAME OF DECEASED (Type or Print) <u>Charles Wilkerson</u>					2. DATE AND HOUR OF DEATH <u>12-2-66</u> <u>5:15 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u> D. STREET ADDRESS (If rural, give location) <u>150 Chestnut St.</u>				
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>06-15-00</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas Wilkerson</u>					14. MOTHER'S MAIDEN NAME <u>Mary ?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-07-0077</u>		17. INFORMANT <u>Hospital Record.</u>				
18. <u>430.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>pulmonary edema</u> <u>Cerebral Vascular Accident</u> <u>Severe Arteriosclerotic Viscular disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Malnourishment - Dehydration</u>									
19A. DATE OF OPERATION <u>12-1-66</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gangrene Rt toe.</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>11-26-</u> <u>1966</u> to <u>12-2-</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>12-2-</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Ronald D. Snyder M.D.</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>12-2-66</u>				
23C. PHYSICIAN'S NAME (Type) <u>Ronald D. Snyder, M.D.</u> M.D.					23D. ADDRESS <u>Maryland General Hospital.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-6-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. CALVARY</u>		24D. LOCATION (City, town, or County) (State) <u>A.A.C. Md.</u>			
25A. DATE REC'D. BY HEALTH DEPT. <u>DEC 5 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Felt</u>		25C. FUNERAL DIRECTOR <u>MORTON T. Dyett</u>		ADDRESS <u>1701 LAURENS</u>			

Received of the Treasurer of the

Board of Directors of the

City of New York

the sum of \$100.00

for the purchase of

City of New York

for the purchase of

for the purchase of

for the purchase of

for the purchase of

for the purchase of

for the purchase of

for the purchase of

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for the purchase of

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12155</u>	
BIRTH NO. <u>66 12155</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Thomas Jones</u>		2. DATE AND HOUR OF DEATH <u>Dec 2, 1966</u> <u>5<sup>30</sup></u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore Gen Hosp</u> <u>43</u>		A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>25-32</u>	
		D. STREET ADDRESS (If rural, give location) <u>1008 Shellbank Rd</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED <u>Widower</u>	8. DATE OF BIRTH <u>3/24/1908</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not known</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>UNK.</u>		11. BIRTHPLACE (State or foreign country) <u>Opelika, Ala.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>? Joe Jones</u>		14. MOTHER'S MAIDEN NAME <u>? Bessie Jones</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT <u>Bessie Joiner</u> ADDRESS <u>2468 Md. ST. (Indiana)</u>	
18. <u>432.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (B) <u>Cerebral Vascular Accident</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>? 4+ years</u> <u>6 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, sheet, office bldg., etc.) <u>No</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>No</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (this hospital) attended the deceased from <u>Nov. 22</u> 19 <u>66</u> to <u>Dec 2</u> 19 <u>66</u> , that (we) lost saw the deceased alive on <u>Dec 2</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) view the body after death.					
23A. SIGNATURE <u>William J. Smith</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Dec. 2, 1966</u>	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS _____			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-6-66</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Felt</u>		25C. FUNERAL DIRECTOR <u>North &amp; Dwyer</u> ADDRESS <u>1701 Lawrence</u>	

2000

1/4 1/2 1/4

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1/2 1/4

1/2 1/4

1/2 1/4

1/2 1/4



# FUNERAL DIRECTOR: IMPORTANT

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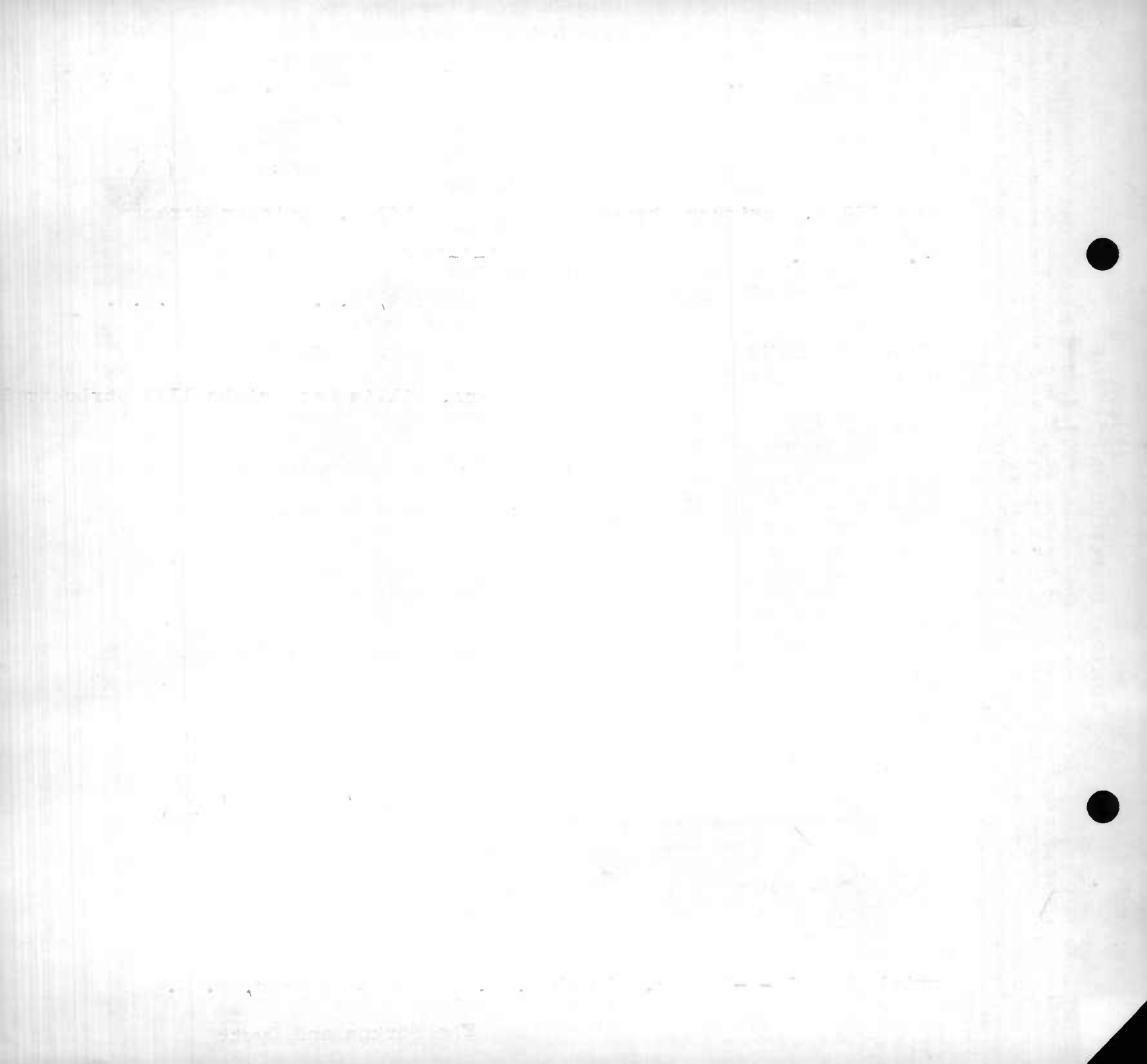
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12156</b>	
BIRTH NO. <b>66 12156</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BERTHA GREENE</b>		2. DATE AND HOUR OF DEATH <b>December 2 1966 8:55 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>24 N. Mount Street</b>			
5. SEX <b>F.</b>	6. RACE <b>N.</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>	8. DATE OF BIRTH <b>1-25-1909</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balt. Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Cooper</b>			14. MOTHER'S MAIDEN NAME <b>Francis Allen</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Henry I Greene</b>	
				ADDRESS <b>24 N. Mount St.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD. ↑</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Essential Hypertension</b>		CAUSE OF DEATH (A) <b>Probable Myocardial Infarct, ant.</b> DUE TO (B) <b>ASCVD. ↑</b> DUE TO (C) <b>Essential Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>25 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Chronic</b>				<b>&gt; 2 weeks</b>	
19A. DATE OF OPERATION <b>0 0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 21 1966</b> to <b>Dec 2 1966</b> , that (I) (we) last saw the deceased alive on <b>December 2 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>James A. Quinlan, Jr.</b>				23B. DATE SIGNED <b>12/2/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES A. QUINLAN, JR.</b>				23D. ADDRESS <b>Mary Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-7-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>	
24D. LOCATION <b>Arbutus</b>		24E. (City, town, or county) <b>Md.</b>		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Morton F. Dye</b>	
				ADDRESS <b>1701 Laurens St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

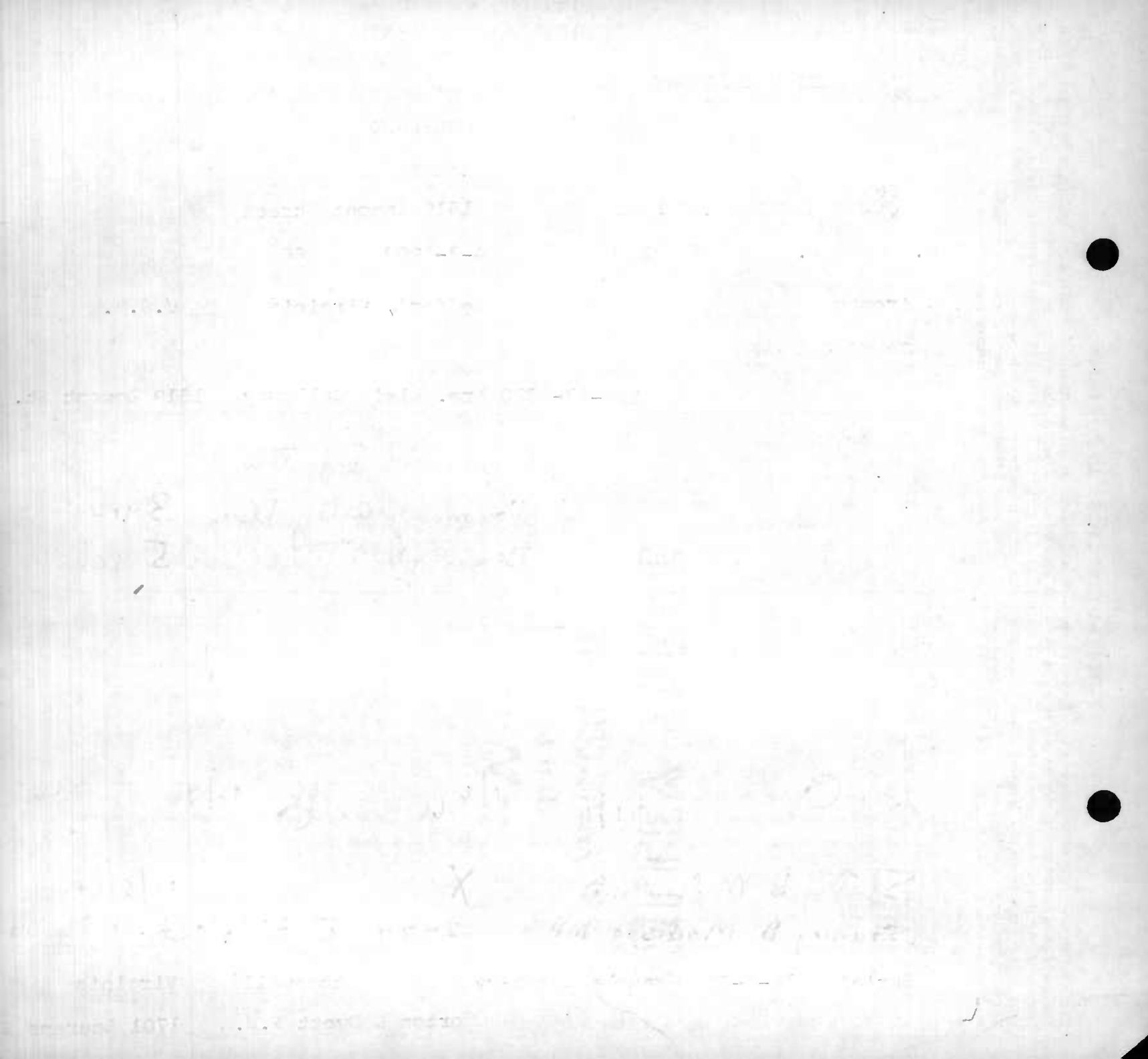
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12157	
BIRTH NO. 66 12157		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES C. WRIGHT</b>		2. DATE AND HOUR OF DEATH <b>December 3, 1966</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>1359 N. Stricker Street</b>			
5. SEX <b>M.</b>	6. RACE <b>N.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-3-1907</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF_EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>SUMPTER, S.C.</b>	
13. FATHER'S NAME <b>CHARLES WRIGHT</b>		14. MOTHER'S MAIDEN NAME <b>KATIE WRIGHT</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Willie Mae Wright 1359 Stricker S</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 4 1965</b> to <b>Dec 3 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 3 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ralph W. Reckling</b>				23B. DATE SIGNED <b>12/3/66</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>426 N. Gilman Street Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Burial</b>		<b>12-8-66</b>		<b>Mt. Pisgah A.M.E. CEMETERY</b>	
				<b>Sumpter, S. C.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>DEC 5 1966</b>		<b>Robert E. Fairbank</b>		<b>The Morton and Dyett</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12158				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 12158	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ELIJAH CALLOWAY</b>				2. DATE AND HOUR OF DEATH <b>December 4, 1966</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1519 Lamont Street</b>			
5. SEX <b>M.</b>	6. RACE <b>N.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-2-1900</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Bedford, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JAMES CALLOWAY</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>226-17-9320</b>		17. INFORMANT ADDRESS <b>Mrs. Elsie Calloway 1519 Lomont St.</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Artery Disease 3 yrs -</b> <b>Generalized Atherosclerosis 5 yrs</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
18. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>—</b>				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/6</b> 19 <b>66</b> to <b>12/4</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>11/11</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Stanley D. Madison, MD</b> M.D.				23B. DATE SIGNED <b>12/5/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Stanley D. Madison, MD</b> M.D.				23D. ADDRESS <b>2444 E Biddle St Balt, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-7-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Manoba Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Stonewall Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Falek</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F.H.</b>		ADDRESS <b>1701 Laurens S</b>	



66 12159

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12159

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

VENISHER Gardner NELSON

2. DATE AND HOUR PRONOUNCED DEAD

December 2, 1966 9:20 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

502 N. Calhoun Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

502 N. Calhoun Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Sep.

8. DATE OF BIRTH

Feb 25-1914

9. AGE (In years  
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Greenville N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

243-03-3098

17. INFORMANT

ADDRESS

ALBERTA Ballenger 1614 W. Mulberry

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/2/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-6-66

23C. NAME of CEMETERY or CREMATORY

CARVER Mem. Laurel, 4nd.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 5 1966

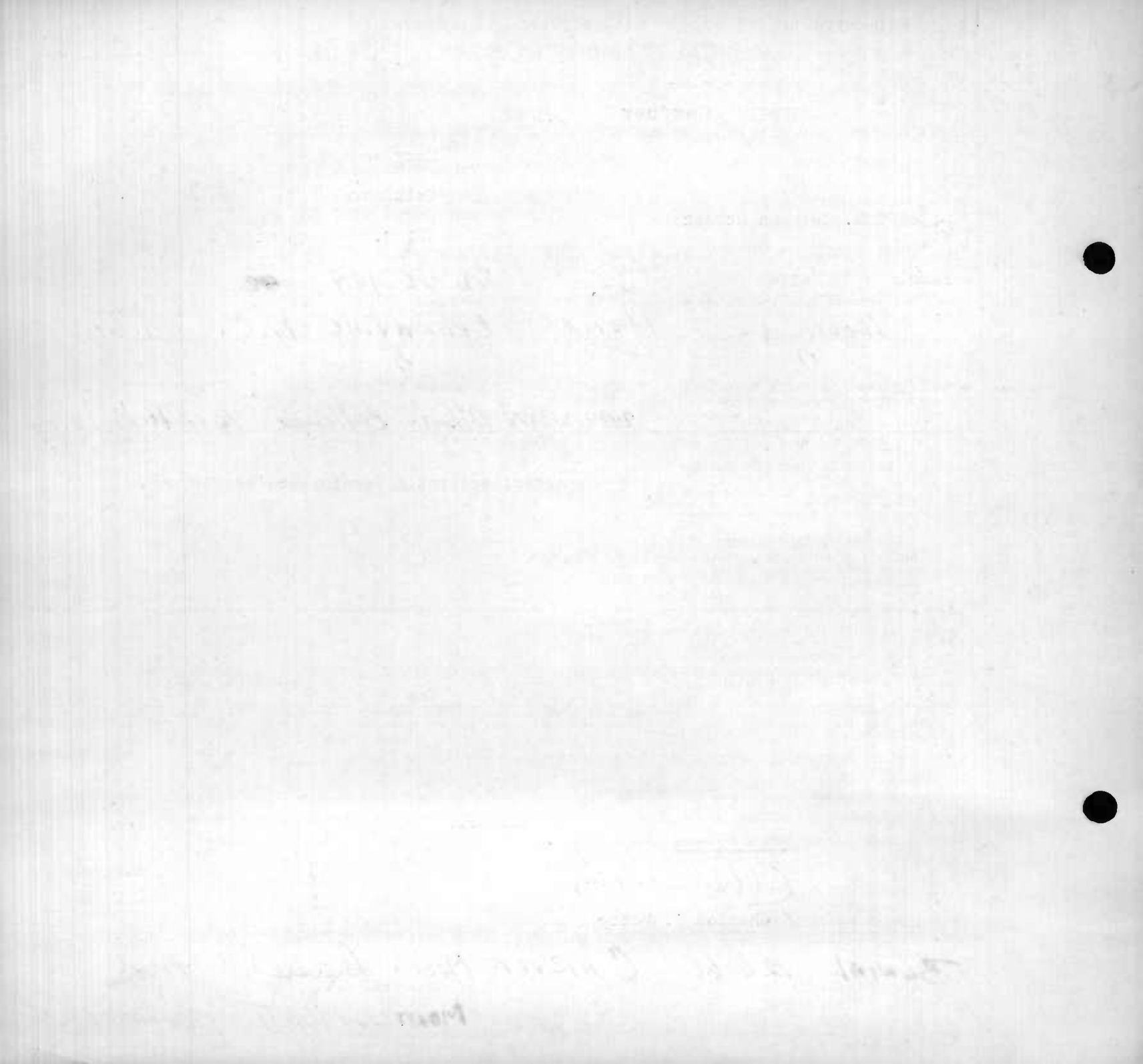
24B. NAME OF REGISTRAR

Albert E. Fairbank

24C. FUNERAL DIRECTOR

MORTON + DGETT 1701 LAURENS

ADDRESS

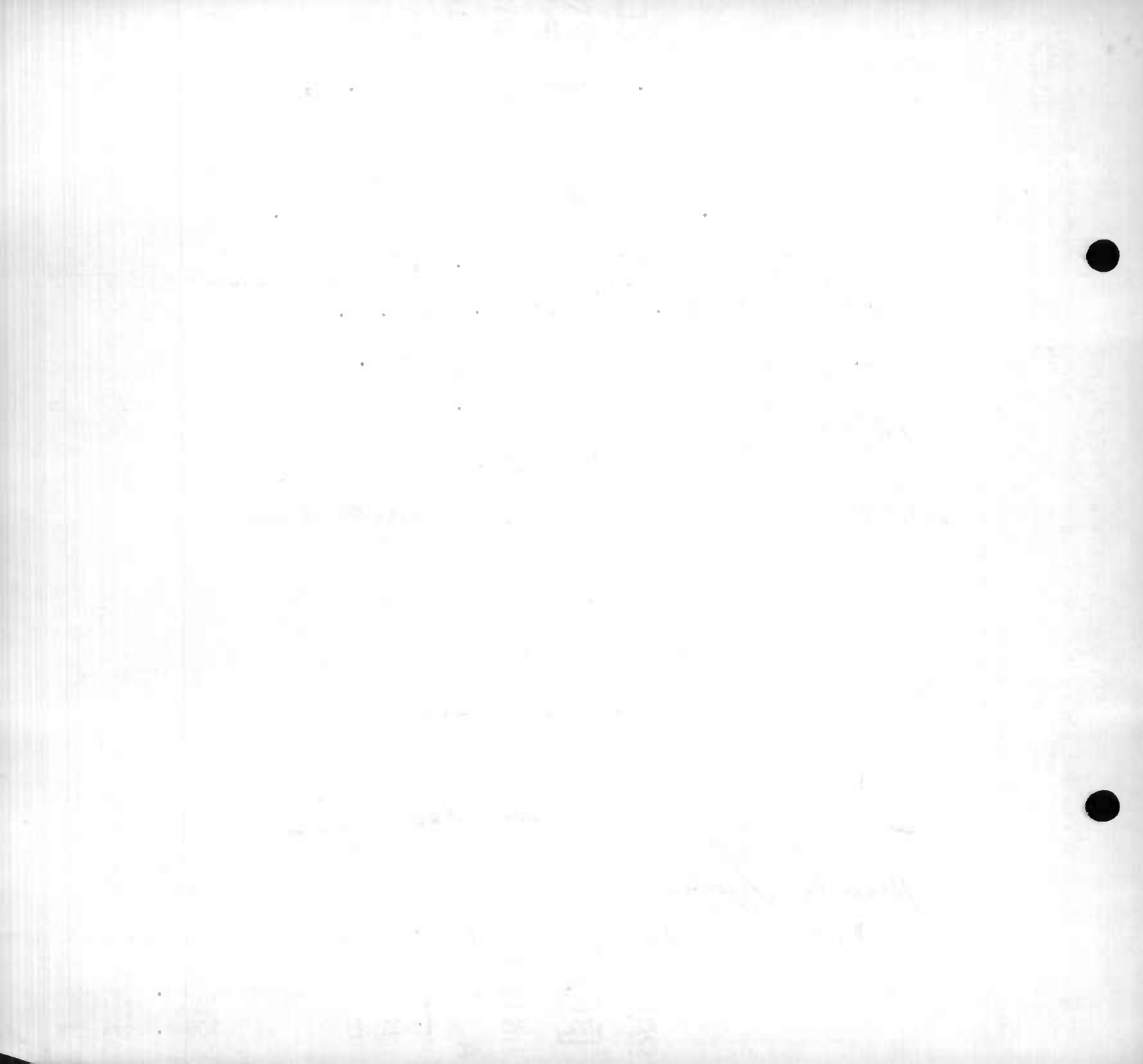




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12160	
BIRTH NO. 66 12160		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Andrew D. Hodgson</b>		2. DATE AND HOUR OF DEATH <b>Nov. 30, 1966 12:00 A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>00 1623 Patapsco St.</b>		A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1623 Patapsco St.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 17, 1916</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Water Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Fred W. Hodgson</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Jackson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ida Hodgson</b>	
				ADDRESS <b>1623 Patapsco St</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>163 X I</b>		CAUSE OF DEATH (A) <b>Carcinoma of the</b> DUE TO (B) <b>lung to metastasis</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 1966</b> to <b>November 29 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov. 29 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ricardo Lopez</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/30/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARDO LOZADA</b>		23D. ADDRESS M.D. <b>12785 Charles St. Balt. 30, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12 3 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>East New Market</b>	
				24D. LOCATION (City, town, or county) (State) <b>Dorchester Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairman</b>		25C. FUNERAL DIRECTOR <b>McCully</b>	
				ADDRESS <b>130 E. Fort Ave</b>	



1  
D-500

66 12161

BALTIMORE CITY HEALTH DEPARTMENT

66 12161

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (ZELMA) Thelma DEAN 2. DATE AND HOUR PRONOUNCED DEAD December 2, 1966 12:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-04

917 N. Monroe Street D. STREET ADDRESS (If rural, give location) 917 N. Monroe Street

5. SEX Female 6. RACE Negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH April 15, 1917 9. AGE (In years last birthday) 49

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Lynchburg, Virginia 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Bonnell 14. MOTHER'S MAIDEN NAME Eva Coleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Community Funeral Home Lynchburg, Virginia

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease.

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 12/2/66

23A. BURIAL CREMATION, REMOVAL (Specify) Removal 23B. DATE 12/3/66 23C. NAME of CEMETERY or CREMATORY Forest Hill Burial Pk., Campbell Co. 23D. LOCATION (City, town, or county) (State) U.P.

24A. DATE REC'D BY HEALTH DEPT. DEC 5 1966 24B. NAME OF REGISTRAR Robert E. Fairman 24C. FUNERAL DIRECTOR Delaigton Phillips 24D. ADDRESS 1727 N. Monmouth

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12162	
66 12162		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Eddie Grant.		30 Nov 1966 7 <sup>20</sup> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland	
5. SEX		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Male		Baltimore	
6. RACE		D. STREET ADDRESS (If rural, give location)	
Negro		1016 N. Carey Street 21217	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Married		7-7-1906	
9. AGE (In years last birthday)		10. AGE (In years last birthday)	
60		60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Constructor		South Carolina	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Sam Grant		Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		249-05-7690	
17. INFORMANT		ADDRESS	
RECORDS: BCH		4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
150 X I		Respiratory arrest.	
ANTECEDENT CAUSES		Esophageal Ca. - metastatic	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		14 months	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Yes		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from November 17 19 66 to 30 Nov 19 66, that (H) (we) last saw the deceased alive on 30 Nov 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Dudley A. Raine, Jr.		30 Nov 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Dr. Dudley A. Raine, Jr.		4940 Eastern Avenue Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		12/5/66	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Ashburton Mem. Pk.		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
DEC 5 1966		Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
Wilmington Phillips		1727 N. Mount.	

ASSC

1957-1958

Residential Survey  
February 1958

Yes

Robert A. Gandy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12163	
BIRTH NO. 66 12163		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles ERNST		2. DATE AND HOUR OF DEATH 12-3-66 8:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore 21230	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS 1613 Race Street	
5. SEX M.	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-14-1889	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill wright		10B. KIND OF BUSINESS OR INDUSTRY Mill		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Simon Ernst		14. MOTHER'S MAIDEN NAME Theresa Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family	
ADDRESS Same					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute MI		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVDs		(B) DUE TO		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ch. Pylonephritis		(C) DUE TO			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 12-3-1966 to 12-3-1966, that (we) last saw the deceased alive on 12-3-1966 and that (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. F. A. Aboony		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-5-66	
23C. PHYSICIAN'S NAME (Type) R. F. A. Aboony		23D. ADDRESS 1213 Light Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 6 1966		24C. NAME OF CEMETERY or CREMATORY Holy Cross	
24D. LOCATION (City, town, or county) Brooklyn, A. A. Co. Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Mc Cully	
ADDRESS 130 E. Fort Ave					

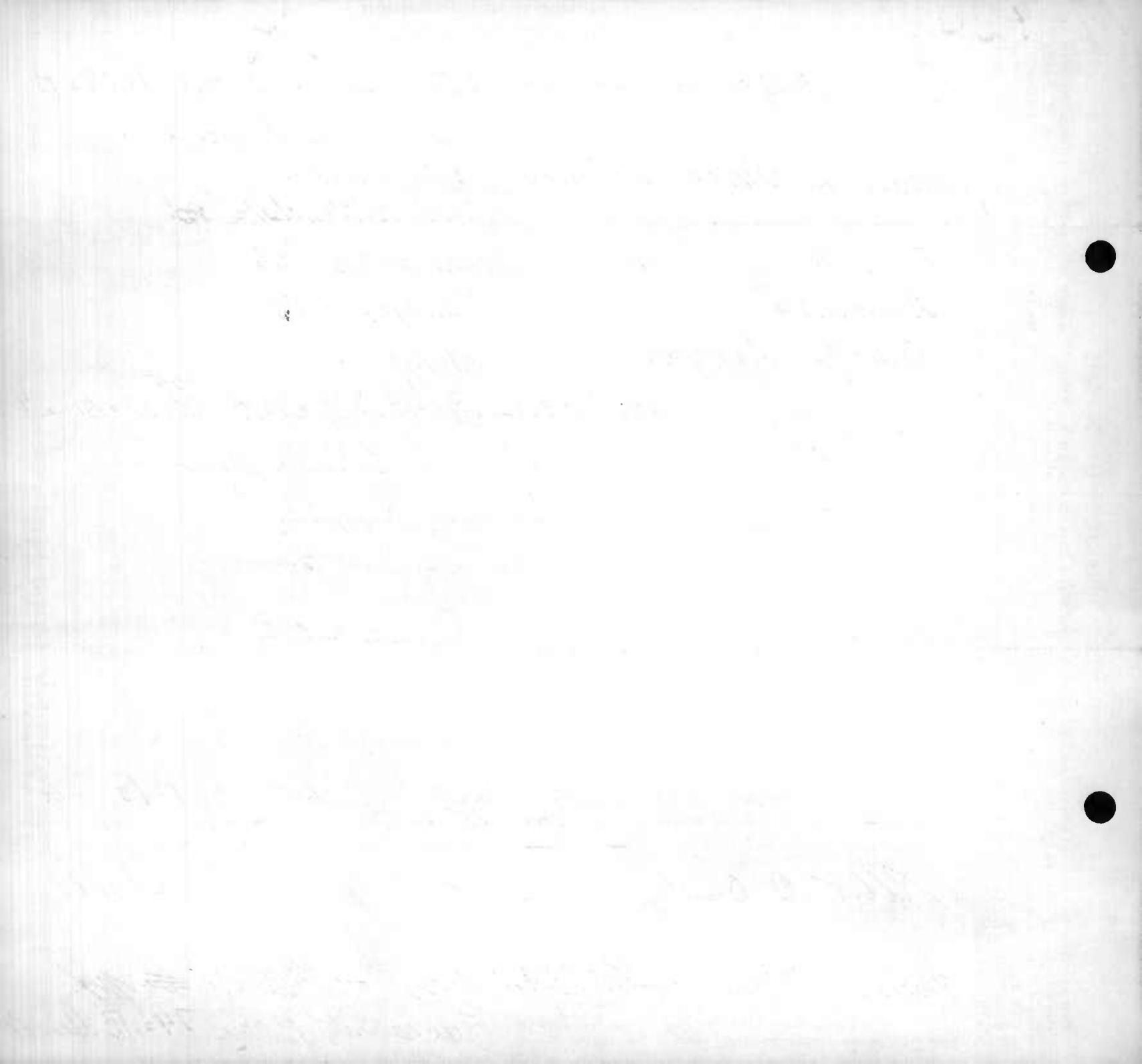




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 12164					CERTIFICATE OF DEATH					Registered No. 66 12164				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <i>Angeline L. Mellott</i>					2. DATE AND HOUR OF DEATH <i>December 3, 1966 11:48 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					5. STATE B. COUNTY <i>Md. Baltimore Co.</i>				
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>House in Pines Bel Air</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					D. STREET ADDRESS (If rural, give location) <i>8005 Hilledale Rd.</i>				
6. SEX <i>F</i>		7. RACE <i>W</i>		8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W.</i>		9. AGE (In years last birthday) <i>Mar 14-1890 76</i>		10. DATE OF BIRTH		11. BIRTHPLACE (State or foreign country) <i>Hancock Md.</i>		12. CITIZEN OF WHAT COUNTRY?		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY					13. FATHER'S NAME <i>Joseph Landers</i>				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME <i>Mary ?</i>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <i>320-09-3192</i>					17. INFORMANT <i>Ernest A Mellott</i>					18. ADDRESS <i>105 Burke Ave 4</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>4-34-14-260X</i>					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO <i>Acute Corbary Vascular Disease</i>									
ANTECEDENT CAUSES					(B) DUE TO <i>Circulatory Insufficiency</i>									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) <i>Congestive Heart Failure</i>									
II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<i>Diabetes mellitus</i>				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1965</i> to <i>12/3 1966</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Nov 25 1966</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.														
23A. SIGNATURE <i>Albert D. Bradley</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>12/3/66</i>				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>12/5/66</i>					24C. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>				
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>					25A. DATE REC'D BY HEALTH DEPT. <i>DEC 6 1966</i>					25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>				
25C. FUNERAL DIRECTOR <i>Jas. J. Home</i>					25D. ADDRESS <i>7401/3rd Ave Rd</i>									



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		66 12165		66 12165	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
COLWELL, DOROTHY F.		12/31/66		7:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MARYLAND 21229		MARYLAND		GLEN BURNIE	
5. SEX		6. DATE OF BIRTH		9. AGE (In years last birthday)	
FEMALE		12/3/10		56	
7. RACE		8. DATE OF BIRTH		10. AGE (In years last birthday)	
WHITE		12/3/10		56	
11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		12. CITIZEN OF WHAT COUNTRY?			
WIDOWED		USA			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SECRETARY		MARYLAND		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
D. Elmer Fischer		Mary Mae Hill			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		216-03-1444		ADDRESS 21229	
18. CAUSE OF DEATH		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4 20.1 I		Acute myocardial infarction			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 3 1966 to DECEMBER 3 1966, that (X) (we) last saw the deceased alive on DECEMBER 3 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
S. Korbuly		12/3/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
SUSANNA KORBULY		ST. AGNES HOSPITAL WILKENS & CATON AVE., BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12/7/66		Glen Haven Memorial Pk.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 6 1966		Robert E. Fisher, M.D.		Singleton Funeral Home, Glen Burnie, Md.	

0000

Shipton Farm, Littlehampton

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12166	
BIRTH NO. 66 12166		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EMMA SCHODETZKI		2. DATE AND HOUR OF DEATH 12/4/66 7:39 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE md B. COUNTY Balt. Co		5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md GEN Hospital BALTO md 21201		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO		9. AGE (In years last birthday) 68	
		D. STREET ADDRESS (If rural, give location) 2813 OHIO AVE		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
11. BIRTHPLACE (State or foreign country) VA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES CHRISTOPHER	
14. MOTHER'S MAIDEN NAME ANNA MILBY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-245202	
17. INFORMANT Kenneth R Koskenen MD		ADDRESS		18. 42011 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH CORONARY THROMBOSIS, RECENT, (A) ANT. DESCENDING ART. DUE TO ARTEROSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (u) (this hospital) attended the deceased from 11/24 1966 to 12/4 1966, that (I) (we) last saw the deceased alive on 12/4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth R Koskenen M.D.				23B. DATE SIGNED 12/4/66	
23C. PHYSICIAN'S NAME (Type) Kenneth R. Koskenen M.D.				23D. ADDRESS Md GEN HOSP BALTO md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/66		24C. NAME OF CEMETERY or CREMATORY London Park Cemetery Balto. Md.	
24D. LOCATION (City, town, or county) Balto.		24E. (State) Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1966	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Robert [unclear] ADDRESS		25D. SINGLETON FUNERAL HOME/CLAY BURNIE MD	



66 12167

BALTIMORE CITY HEALTH DEPARTMENT

66 12167

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)PAUL ~~HERAUF~~ HERAUF

2. DATE AND HOUR PRONOUNCED DEAD

December 3, 1966 3:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

~~Baltimore~~ Glen Burnie, Md. 52-00

D. STREET ADDRESS (If rural, give location)

1811 Ballman Court 707 Baylor Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

19 July 1944

9. AGE (in years  
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Fireman

10B. KIND OF BUSINESS OR INDUSTRY

Balto, City F.O.

11. BIRTHPLACE (State or foreign country)

Anne Arundel Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John L. Herauf

14. MOTHER'S MAIDEN NAME

Natalie F. Jozwiak

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1963 - 1964

16. SOCIAL  
SECURITY NO.

218-42-1671

17. INFORMANT

John L. Herauf - Same as # 4

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebrocranial injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

11-29-66

19B. CONDITION FOR WHICH OPERATION

Sub dural Hematoma

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

highway

21C. WHERE DID (If in Baltimore City, give exact location)

Key Highway - 680 feet north  
of Mc Comas Street.21D. TIME  
OF INJURY  
(APPROX.)

11-29-66

(Month) (Day) (Year) (Hour)

11:25 A

21E. INJURY OCCURRED

WHILE AT WORK ☒NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Fell from moving Fire Engine

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7 Dec. 66

23C. NAME of CEMETERY or CREMATORY

Glen Haven Memorial Ph.

23D. LOCATION

Glen Burnie, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 6 1966

24B. NAME OF REGISTRAR

Robert E. Faldut

24C. FUNERAL DIRECTOR

Singleton Funeral Home/Glen Burnie, Md.

ADDRESS

WALLLEY FORD

40% FIVE MINUTE

11-11-75

11-11-75

11-11-75

11-11-75



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66-12168 <b>CERTIFICATE OF DEATH</b>		Registered No. 66 12168 4	
BIRTH NO. 66 12168 M.E. CASE NO.		2. DATE AND HOUR OF DEATH DEC-4-66 120 A.M.	
1. NAME OF DECEASED (Type or Print) <b>Boy INGRAM</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MD. GENERAL HOSPITAL</b>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> 8. COUNTY <b>Balt. Co</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21227 53-00</b>	
D. STREET ADDRESS (If rural, give location) <b>3163 KESSLER ROAD</b>		5. SEX <b>MALE</b> 6. RACE <b>WHITE</b>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>—</b>		8. DATE OF BIRTH <b>DEC-3-66</b> 9. AGE (In years last birthday) <b>—</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN INGRAM</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES JOELINE Mc GEE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MOTHER</b>		ADDRESS <b>3163 Kessler Rd. Baltimore, 21227 Md.</b>	
18. <b>773.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Distress</b>		CAUSE OF DEATH (A) DUE TO <b>Respiratory Distress</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Immaturity</b>		(B) DUE TO <b>Immaturity</b>	
(C) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>DEC-3-1966</b> to <b>DEC-4-1966</b> , that (I) (we) lost saw the deceased alive on <b>DEC-4-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <b>Michael J. Reilly</b> M.D.		23B. DATE SIGNED <b>12-4-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Michael J. Reilly</b> M.D.		23D. ADDRESS <b>MD. Gen'l Hosp. Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-5-66</b>	
24C. NAME of CEMETERY or CREMATORY <b>Glenn Haven Memorial PK</b>		24D. LOCATION (City, town, or county) (State) <b>Glenn Burnie, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Robert P. ...</b>		ADDRESS <b>Singleton Funeral Home / Glenn Burnie, Md.</b>	

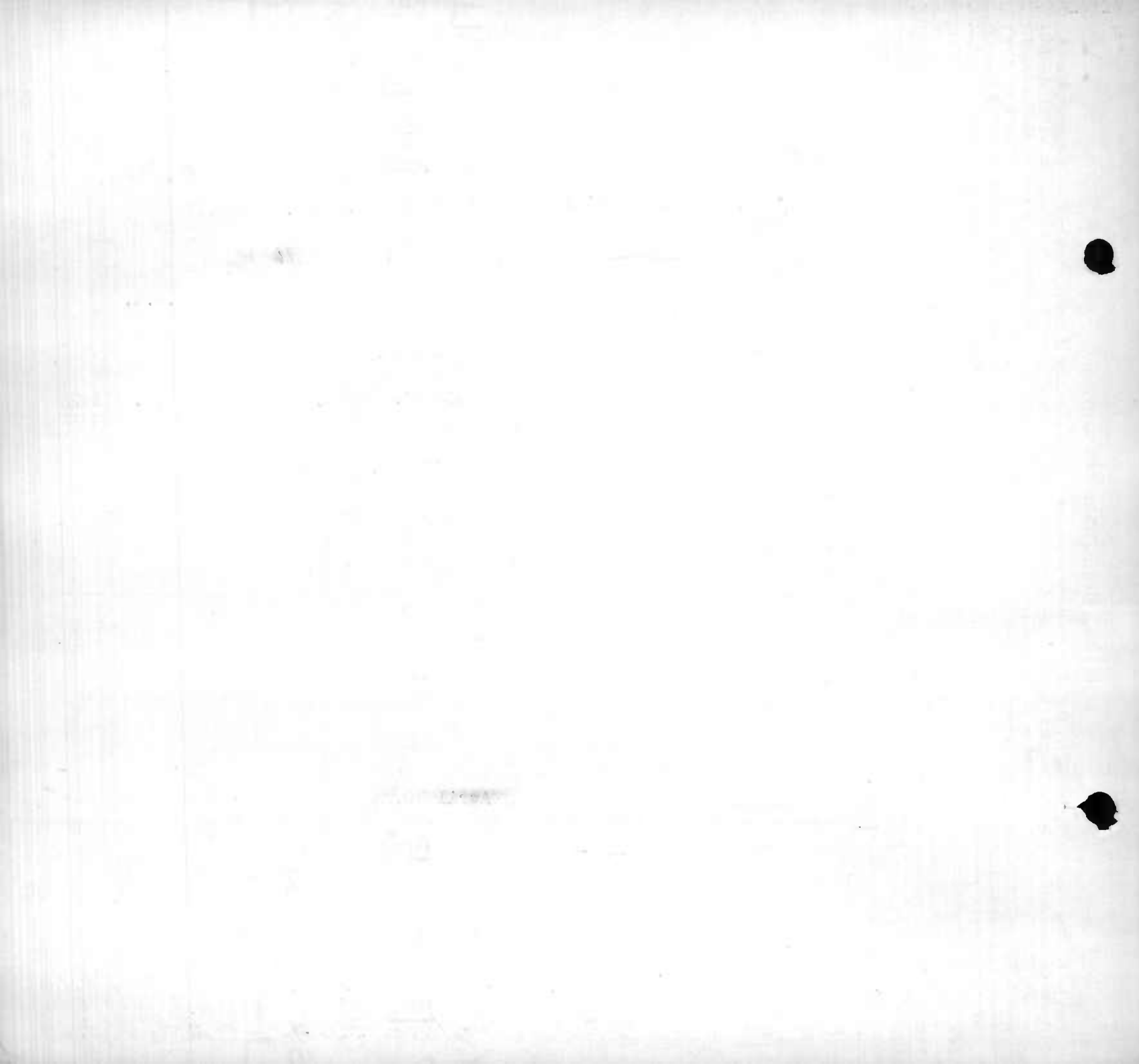
Michael J. Kelly

1220 Glen Haven Avenue St. Paul, Minn.  
English translation of the text

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12169				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12169	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Harri's Alexander Harrison</i>				2. DATE AND HOUR OF DEATH <i>11/30/66</i> <i>16 28</i> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31</i> <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>1357 FREEMONT AVE. #21217</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>UNKNOWN widowed</b>	8. DATE OF BIRTH <i>Dec 17</i> <b>1889</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <i>unknown</i>				
14. MOTHER'S MAIDEN NAME <i>unknown</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				
16. SOCIAL SECURITY NO.			17. INFORMANT <b>RECORDS: BCH 4940 EASTERN AVE. #21224</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <i>5-78X I</i> <b>Hypovolemic Shock</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Anteneclosclerosis</i>				(B) <b>Probable Gastrointestinal Bleeding</b> <b>2 days</b>			
(C) <b>unknown lesion</b>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>April 20, 1966</i> to <i>November 30, 1966</i> . that (I) (we) lost saw the deceased alive on <i>November 30, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Joseph Silva</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Nov 30, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <b>DR. JOSEPH SILVA</b>				23D. ADDRESS M.D. <b>4940 EASTERN AVENUE #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-6-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balti. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 6 1966</i>		25B. NAME OF REGISTRAR <i>Dr. J. E. Feltner</i>		25C. FUNERAL DIRECTOR <i>Sullivan Funeral Home - 1011-13</i>		ADDRESS <i>N. Arlington Ave.</i>	



1  
F-425

66 12170

BALTIMORE CITY HEALTH DEPARTMENT

66 12170

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

NORMAN FAULKNER

2. DATE AND HOUR PRONOUNCED DEAD

December 3, 1966 12:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Trappe

D. STREET ADDRESS (If rural, give location)

70-00

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
never married

8. DATE OF BIRTH

Feb. 26, 1910

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Lumberman

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
COUNTRY?

USA

13. FATHER'S NAME

R. James Faulkner

14. MOTHER'S MAIDEN NAME

Martha Coleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW 11

16. SOCIAL  
SECURITY NO.

Unkn.

17. INFORMANT

ADDRESS

Ephriam Diefenderfer, Trappe, Md.

18. 5910.5

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebrocranial injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

312-2-66

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Depressed skull fracture

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Saw mill

21C. WHERE DID  
(If in Baltimore City, give exact location)  
INJURY OCCUR?

Eastern Saw Mill

70-00

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
12-2-66 about 9:45 A.

21E. INJURY OCCURRED

WHILE AT  
WORK☒NOT WHILE  
AT WORK☐

21F. HOW DID INJURY OCCUR?

Log struck subject on head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/6/1966

23C. NAME OF CEMETERY or CREMATORY

Upper Bambury Cemetery

23D. LOCATION

Trappe, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 6 1966

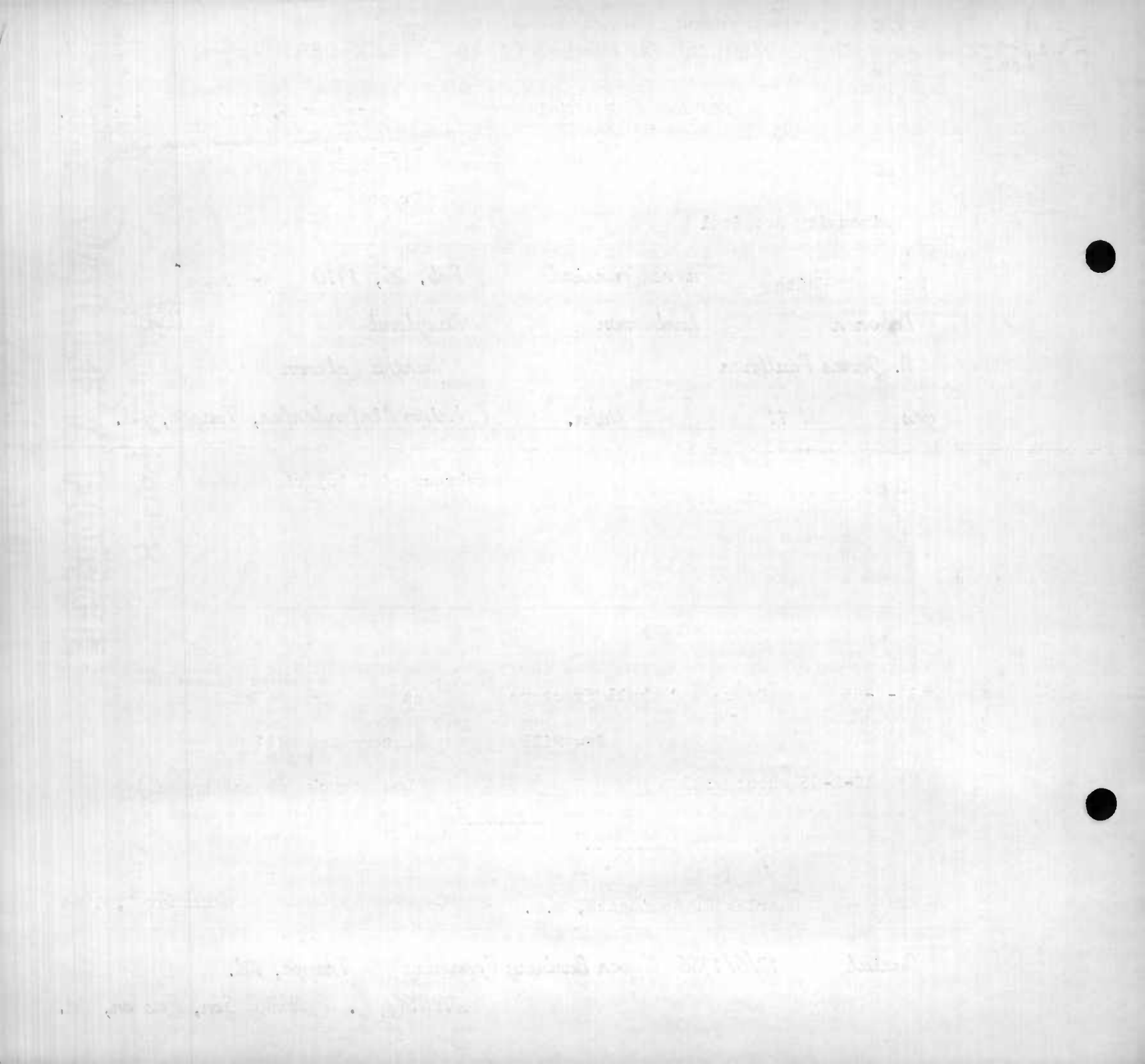
24B. NAME OF REGISTRAR

Robert E. Farkner

24C. FUNERAL DIRECTOR

MAURICE E. NEUNAM &amp; Son, Easton, Md.

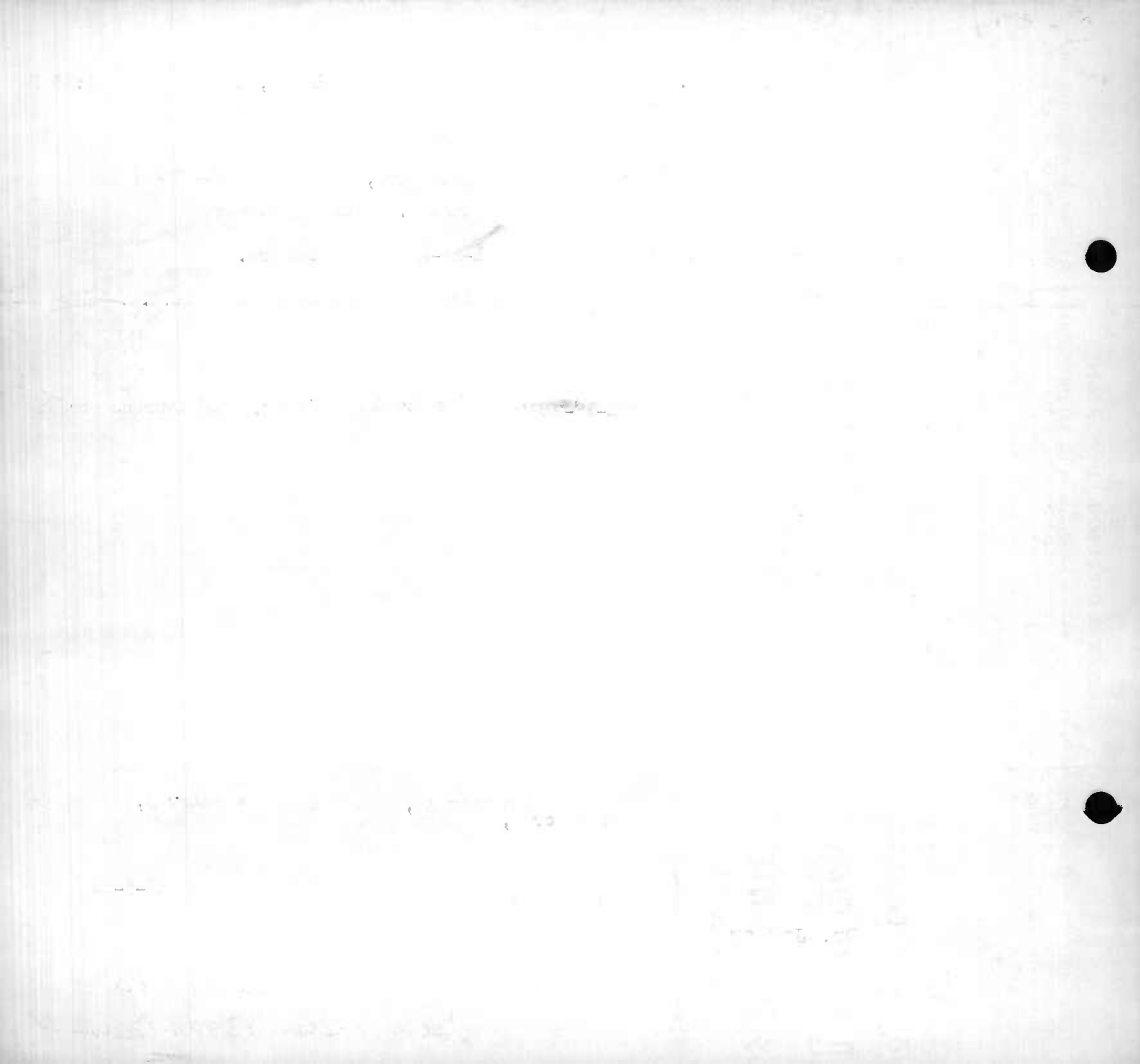
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. <u>66 12171</u>	
BIRTH NO. <u>66 12171</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Eleanor B. Conley</b>			2. DATE AND HOUR OF DEATH <b>December 3, 1966</b> <b>4:35 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>15-03</b> D. STREET ADDRESS (If rural, give location) <b>1641 N. Smallwood Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1-25-16</b>	9. AGE (In years lost birthday) <b>50 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>231-18-2194</b>		
17. INFORMANT <b>Agnes Brooks (Sister)</b>			ADDRESS <b>508 Laurens Street</b>		
18. <b>710X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>congestive heart failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pulmonary infarct</b>			CAUSE OF DEATH (A) DUE TO <b>congestive heart failure</b> (B) DUE TO <b>rheumatic heart disease with aortic and mitral 35 years.</b> (C) <b>pulmonary infarct</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>one week</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 14, 1966</b> to <b>December 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 3, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Margie Jones</b> M.D.			23B. DATE SIGNED <b>12-5-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. Javier</b>			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/8/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>First Bab.</b>	
24D. LOCATION (City, town, or county) (State) <b>Heathsville Va</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>DEC 8 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fellers</b>		25C. FUNERAL DIRECTOR <b>Geo. H. Nelson</b>			
25D. ADDRESS <b>1348 N. Calhoun</b>					

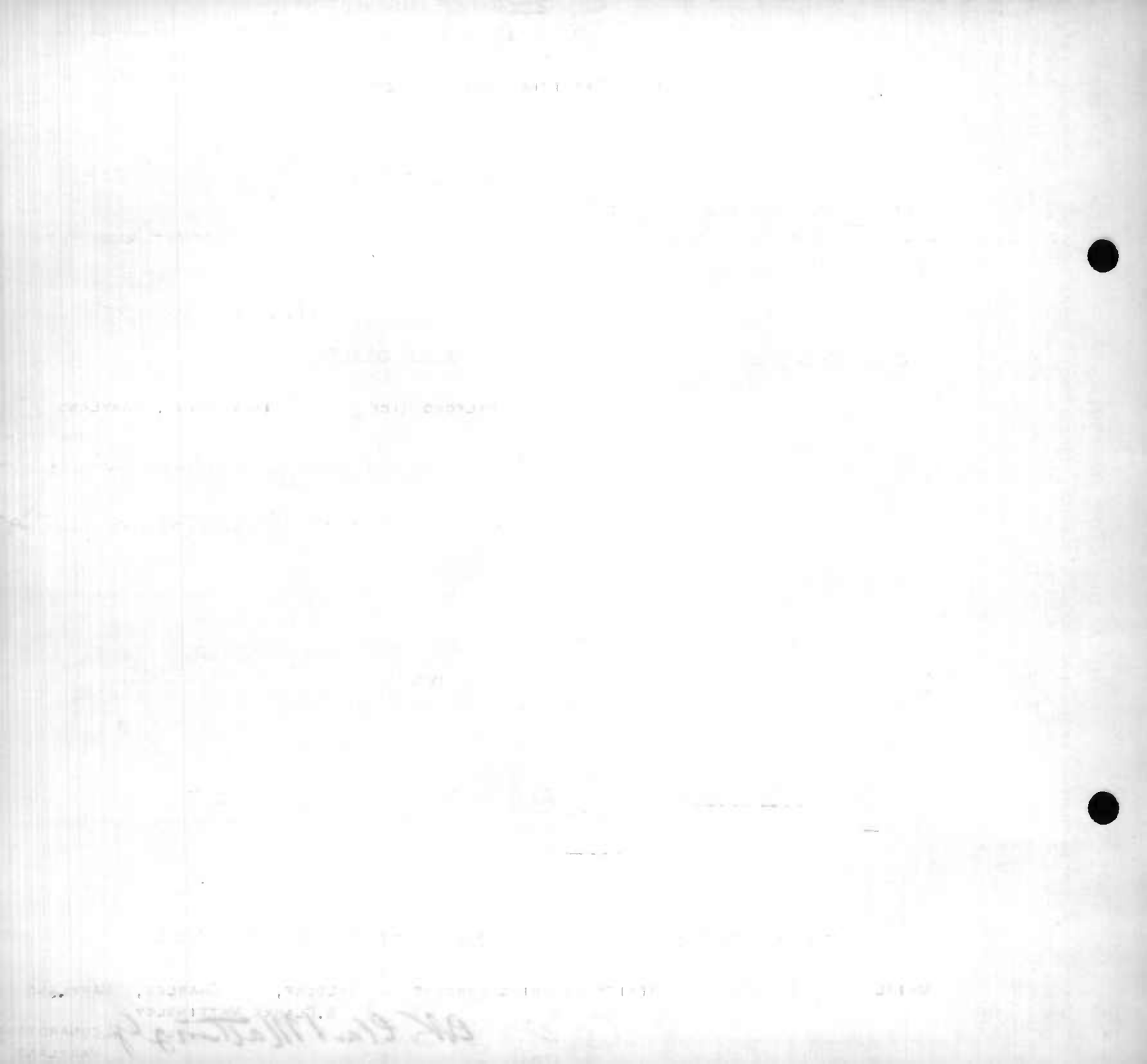




# FUNERAL DIRECTOR: IMPORTANT

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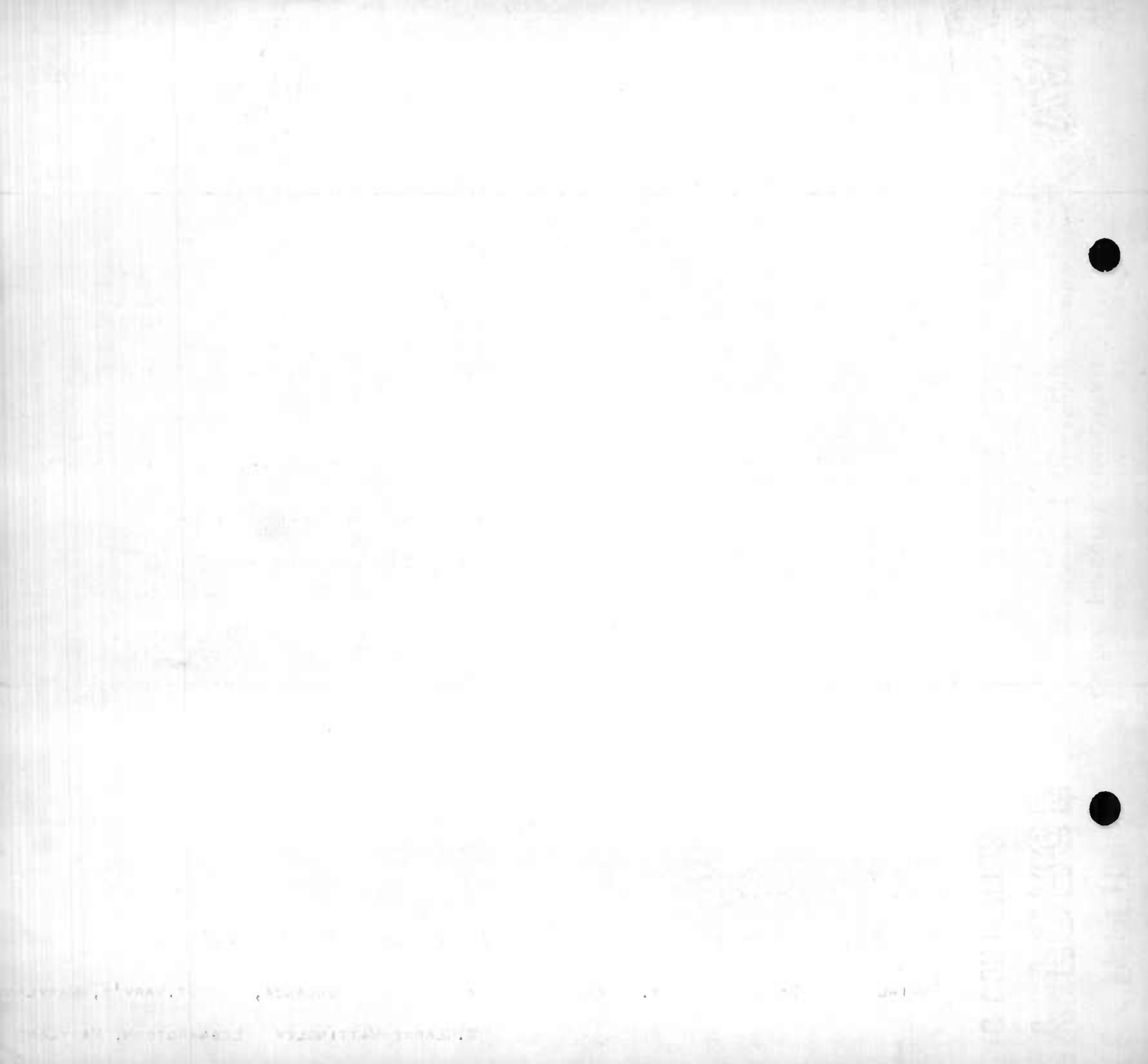
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12172	
BIRTH NO. 66 12172		CERTIFICATE OF DEATH		Registered No. 66 12172	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) Rice Tillie P.		PATRICIA ANN		Dec. 2, 1966 7:15 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		Md.		St. Marys	
33 The Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Piney Point	
		D. STREET ADDRESS (If rural, give location)		68-00	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	W	MARRIED	7/22/28	38	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife				Mass.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		John Kerepka		Anna Olenich	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				MILFORD RICE	
				PINEY POINT, MARYLAND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Invasive Squamous Carcinoma 4 yrs	
ANTECEDENT CAUSES		(B) DUE TO		Recurrent I.C.E. Carcinoma	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/8 19 66 to 12/2 19 66, that (I) (we) last saw the deceased alive on 12/2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Joseph Callea				12-2-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Joseph Callea		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12/6/66		TRINITY MEMORIAL GARDENS	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
WALDORF, CHARLES, MARYLAND				W. CLARKE MATTINGLEY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
		Robert E. Fudge		W. Clarke Mattingley	
VS 150-REV. 1/1/65		DEC 6 1966		LEONARD TOW	
				MARYLAND	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-6-2		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12173	
BIRTH NO. 66 12173		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Ronnie Meredith</b>		2. DATE AND HOUR OF DEATH <b>12/1/66 827 A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Mechanicsville Md.</b> B. COUNTY <b>St. Mary's</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Mechanicsville 68-00</b>			
		D. STREET ADDRESS (If rural, give location) <b>none</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>never married</b>	8. DATE OF BIRTH <b>12-20-52</b>	9. AGE (In years last birthday) <b>13</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Raymond Meredith</b>		14. MOTHER'S MAIDEN NAME <b>Gardie Thomas</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <b>592X1</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Uremia secondary to</b> DUE TO		<b>18 mos.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>chronic glomerulonephritis, 20 hemorrhages</b> DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Hemorrhage, probably due to thrombocytopenia</b>			
19A. DATE OF OPERATION <b>2 none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>none</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>None</b>		22. I certify that (I) (this hospital) attended the deceased from <b>11/30 1966</b> to <b>12/1 1966</b> , that (I) (we) last saw the deceased alive on <b>12/1 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Richard D. Bland</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/1/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard Bland</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/5/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>ST. JOSEPHS CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>MORGANZA, ST. MARY'S, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>W. CLARKE MATTINGLEY</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>LEONARDTOWN, MARYLAND</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12174</span>	
BIRTH NO. <span style="float: right;">66 12174</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Charles S. Fair</i>			2. DATE AND HOUR OF DEATH <i>12/1/66 9:40 AM</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
(If not in hospital or institution, give street address or location)			D. STREET ADDRESS (If rural, give location) <i>4201 Falls Road</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>9/27/05</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Court Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Superior Court</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>United States</i>		13. FATHER'S NAME <i>Samuel Fair</i>			
14. MOTHER'S MAIDEN NAME <i>Grace E. Ford</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>215-10-2586</i>		17. INFORMANT <i>Mrs Helen K. Fair</i>		ADDRESS <i>4201 Falls Rd Baltimore, Md.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Cor pulmonale 2° to Pulmonary emphysema</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <i>Coronary arteriosclerosis ASVD</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>12/1</i> 19 <i>66</i> to <i>12/1</i> 19 <i>66</i> , that (we) last saw the deceased alive on <i>12/1</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John R. Vaughan Jr.</i>				23B. DATE SIGNED <i>12/1/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN R. VAUGHAN, JR.</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/5/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>WOODLAWN</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE County Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 6 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>BURGE FUNERAL HOME 3631 Falls Rd</i>			
25D. ADDRESS <i>William R. Kleiber</i>					

Samuel Fair

Grace Eford

Mr. Mark Fair

See Appendix 2 to

Germany Antiquities  
AND  
Polynesian antiquities

1/22

13/1

13/10

13/1

13/1

THE U. S. NATIONAL MUSEUM

1000

John A. King

66 12175

BALTIMORE CITY HEALTH DEPARTMENT

66 12175

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CONNIE

TRAYNHAM

2. DATE AND HOUR PRONOUNCED DEAD

December 1, 1966

9:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

592 W. Biddle Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3/4/19

9. AGE (in years  
lost birthday)

47

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Henry Conaway

14. MOTHER'S MAIDEN NAME

Missie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr Wesley Traynham 592 W Biddle St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/6/66

23C. NAME of CEMETERY or CREMATORY

Conaway Cemetery

23D. LOCATION (City, town, or county)

Danville

Virginia

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

er W/

limited

Virginia

Domestic

Atlantic

Henry Conway

Mr. Wesley

Telephone 222 W. Main St.

Virginia

Lawville

Conway County

12/10/00

Butler

Abolition Refused 1206 N. Main St.



66 12176

BALTIMORE CITY HEALTH DEPARTMENT

66 12176

BIRTH NO. 61-15427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HELEN ROGERS

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966 4:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37/99 Mercy Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1537 Aisquith Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Child

8. DATE OF BIRTH

4/27/61

9. AGE (In years  
(last birthday))

5

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Harvy Rogers

14. MOTHER'S MAIDEN NAME

Annie Chambers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Jessie McMorris 2006 Robb St

18.

E 916.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia by carbon monoxide  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Conflagration  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

house

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1516 Holbrook Street

21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

12-4-66 3:08 A

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Found on second  
floor of burning house.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/8/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 6 1966

24B. NAME OF REGISTRAR

Robert E. Foy

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

Writer  
 Baltimore Md  
 Anne Chambers  
 The Anne Chambers

Baltimore Md  
 Anne Chambers  
 The Anne Chambers

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

JAMES ROGERS

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966 4:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31/99 Mercy Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1516 Aisquith Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Child

8. DATE OF BIRTH

6/28/62

9. AGE (In years  
last birthday)

4

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Harvey Rogers

14. MOTHER'S MAIDEN NAME

Annie Chambers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Jessie McMorris 2006 Robb St

18.

E 916.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia due to carbon monoxide  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Due to: conflagration  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1516 Holbrook Street

21D. TIME  
OF INJURY  
(APPROX.)

12-4-66 3:08 A

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK21F. HOW DID INJURY OCCUR? Found on second floor  
of burning house.

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/8/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 6 1966

Adolphus Halstead 1206 W North Ave



66 12178  
BIRTH NO. 61-30671  
M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

66 12178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) <b>RALPH MONK</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>December 1, 1966 12:15 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>36 Franklin Square Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>415 N Carey St</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Child</b>	8. DATE OF BIRTH <b>10/25/61</b>	9. AGE (In years last birthday) <b>5</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Azell Monk</b>				14. MOTHER'S MAIDEN NAME <b>Betty L P Leathers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Lucille Monk</b>		ADDRESS <b>415 N Carey St</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocarditis and Interstitial</b> <del>Pneumonitis</del> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Rudiger Breiteneker</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/2/66</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>12/6/66</b>	23C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>		23D. LOCATION (City, town, or county) (State) <b>A A County Md</b>		
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR <b>Robert E. Feltner</b>		24C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>			
				ADDRESS <b>1206 W North Ave</b>			

Mr. H. C. C. C.

12/25/60

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66 12179

BALTIMORE CITY HEALTH DEPARTMENT

66 12179

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH

E.

BOSSIL

2. DATE AND HOUR PRONOUNCED DEAD

December 2, 1966

12:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 1755 N. Gay Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1755 N. Gay Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

7/14/49

9. AGE (In years  
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

School

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

James E Parker

14. MOTHER'S MAIDEN NAME

Gladys Lovett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Gladys Lovett 1755 N Gay St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Rheumatic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/2/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/7/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

WILLIAM H. HODGE

James E. Hodge  
School  
James E. Hodge  
James E. Hodge  
James E. Hodge  
James E. Hodge

James E. Hodge  
James E. Hodge  
James E. Hodge  
James E. Hodge



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12180		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 12180	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JEROME P. EMGE</b>		2. DATE AND HOUR OF DEATH <b>12-5-66</b>   <b>3:00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto. Co</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>   <b>53-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE 29, MARYLAND</b>		D. STREET ADDRESS (If rural, give location) <b>SHANGRI-LA NURSING HOME, HARLEM LANE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>SEPT 4-90</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>MARLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH EMGE</b>		14. MOTHER'S MAIDEN NAME <b>EMMA (GUNTHER)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-44-6267</b>		17. INFORMANT ADDRESS <b>Gloria C. Hamsen-5115 Edmondson Ave ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>241X 17154X</b>		CAUSE OF DEATH (A) DUE TO <b>As thma with complication of heart failure, Shock</b> (B) DUE TO (C) <b>pulmonary fibrosis with Cancer of Rectum</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-26-66</b> to <b>12-5-66</b> , that (I) (we) last saw the deceased alive on <b>12-5-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Nickbakht</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. NICKBAKHT</b>		23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-9-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Stedman</b>	
25C. FUNERAL DIRECTOR <b>Witzke F.D.-4101 Edmondson Ave.</b>		ADDRESS			

DATE OF BIRTH

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Handwritten notes in cursive script, including "Handwritten notes" and "Handwritten notes".

THIRD

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THIRD

Handwritten signature or initials.

THIRD

THIRD

THIRD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

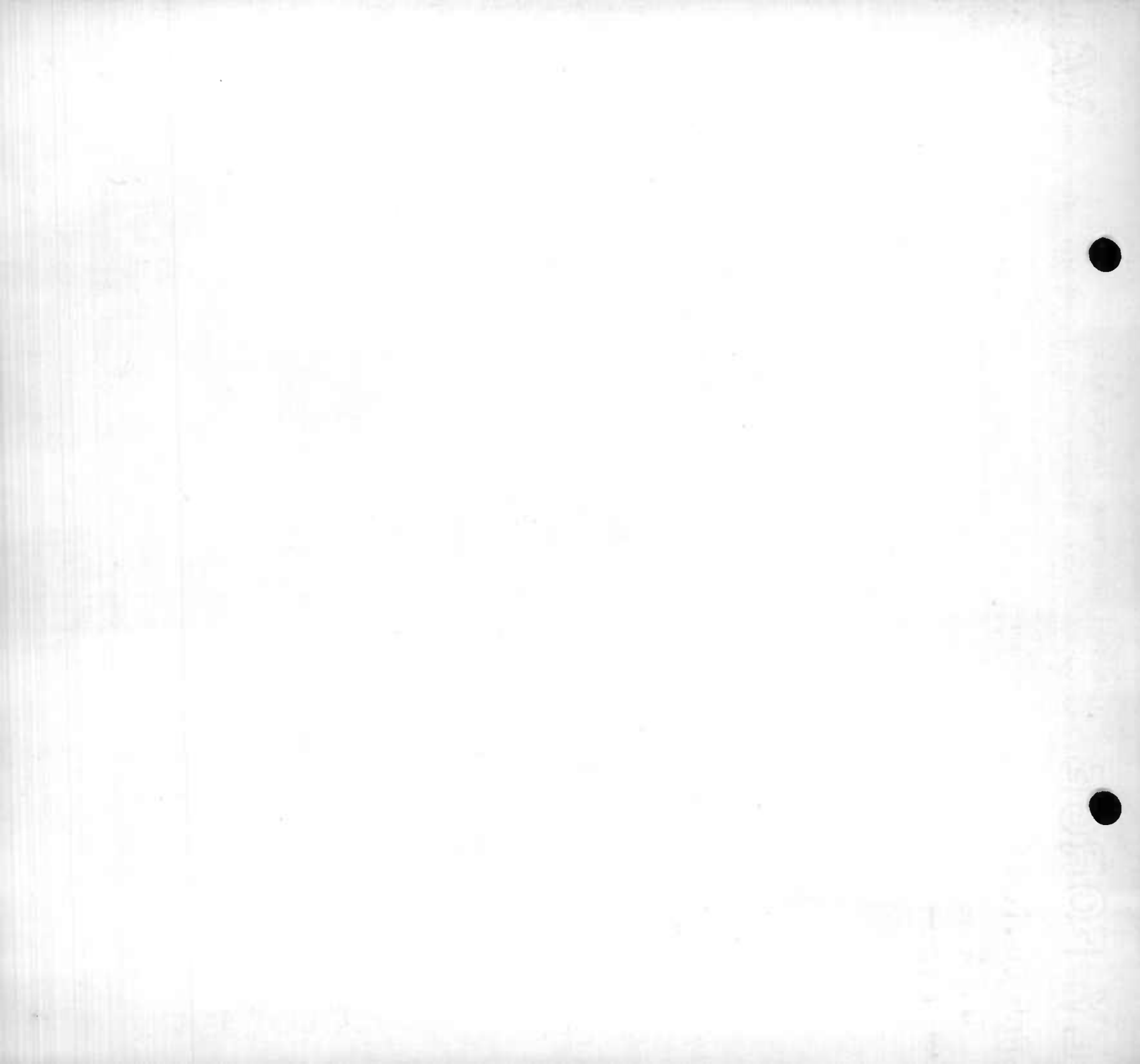
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="float: right;">66 12181</span>	
BIRTH NO. <span style="font-size: 1.5em;">15-160 66 12181</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Orville L. Sparrow		Dec 4 1966 11 <sup>00</sup> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Md. Baltimore			
321 S. Augusta Ave.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
				D. STREET ADDRESS (If rural, give location)		321 S. Augusta Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
M	Wh	Divorced	Mar. 7, 1908	58			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Salesman				Balto., Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Late - John K. Sparrow				Susie (Parrott)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		714-05-6876		Mrs. Susie Sparrow		321 S. Augusta Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>ARTERIO-SCLEROTIC</u> <u>CARDIOVASCULAR DISEASE</u>				5 YRS +	
		(B) DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 45 to 12/4 19 66, that (I) (we) lost saw the deceased alive on 12/3 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Thomas E. Roach</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/5/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Thomas E. Roach				5550 Baltimore National Pike			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-7-66		Olivet Cem.		St. Michaels, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 6 1966		R. E. E. E. E. E.		Witzke F.D.		4101 Edmondson Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

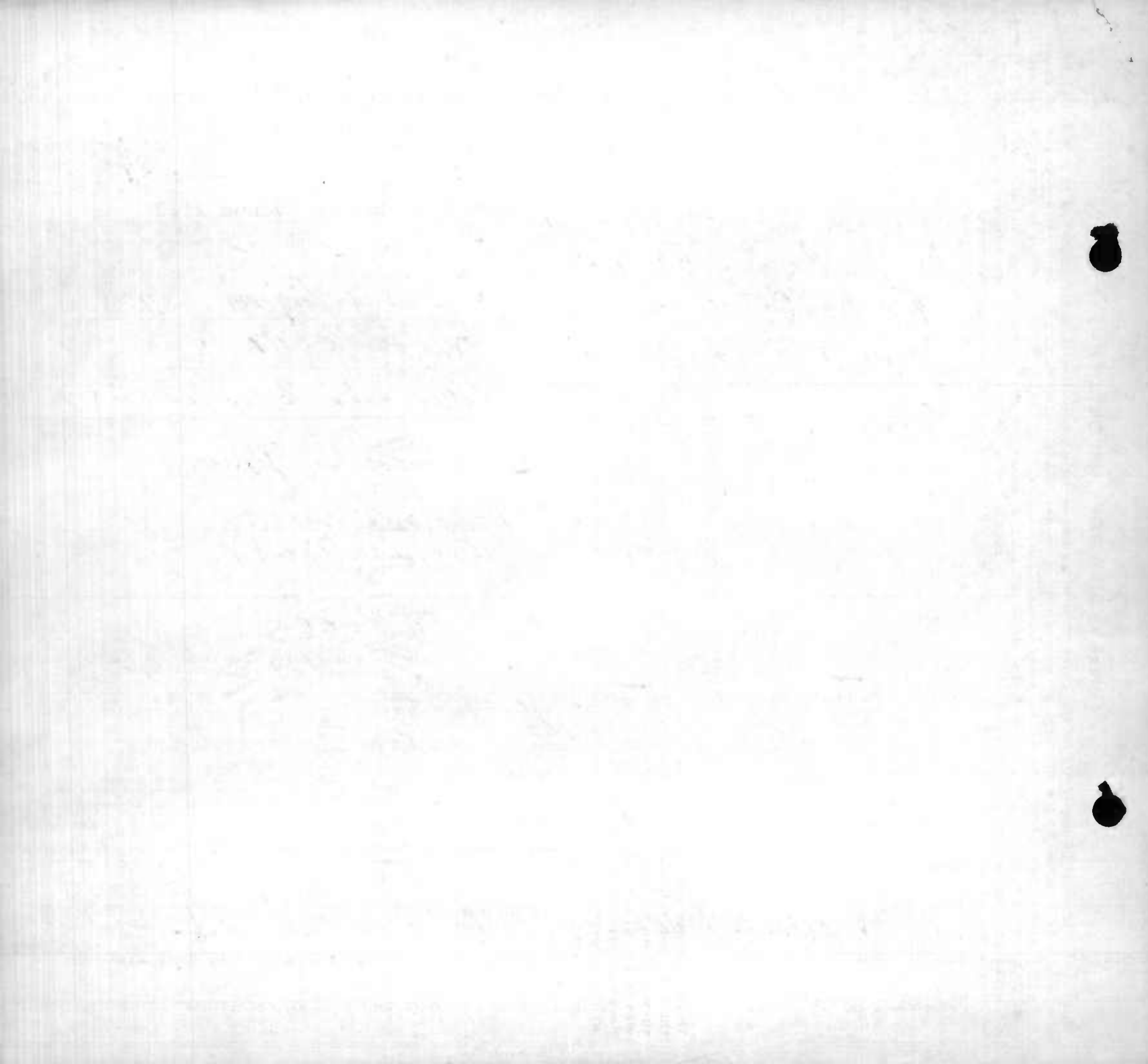
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">66 12182</span>	
BIRTH NO. <span style="font-size: 1.2em;">66-282712182</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Baby Boy Sykes</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/4/66</span> <del>5:30 P</del> <span style="font-size: 1.2em;">15:30 P</span> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">33 Johns Hopkins Hospital</span>		A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 6-02</span>			
		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">Hospital 225 N. Montford Ave</span>			
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">N</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Infant</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12/2/66</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">2</span>	If Under 1 Yr. Months Days Hours Min. <span style="font-size: 1.2em;">2</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Ernest Sykes</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Lorena 225 N. Montford Ave</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Chart Hospital</span>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">771.5 I Prematurity</span>		CAUSE OF DEATH (A) DUE TO <span style="font-size: 1.2em;">? Pulmonary hemorrhage</span> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3 hours</span>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<del>Lawyer</del>			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/2/66</span> 19 to <span style="font-size: 1.2em;">12/4/66</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12/4/66</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Joseph Kaplan</span>		M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">12/4/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Joseph Kaplan</span>		23D. ADDRESS <span style="font-size: 1.2em;">Johns Hopkins Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">CREMATION</span>		24B. DATE <span style="font-size: 1.2em;">12-5-66</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Johns Hopkins Hospital</span>	
24D. LOCATION (City, town or county) (State) <span style="font-size: 1.2em;">BALTIMORE, S. MARYLAND</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 6 1966</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Ruth E. Farber</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">MORTUARY SERVICE - BCHD</span>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

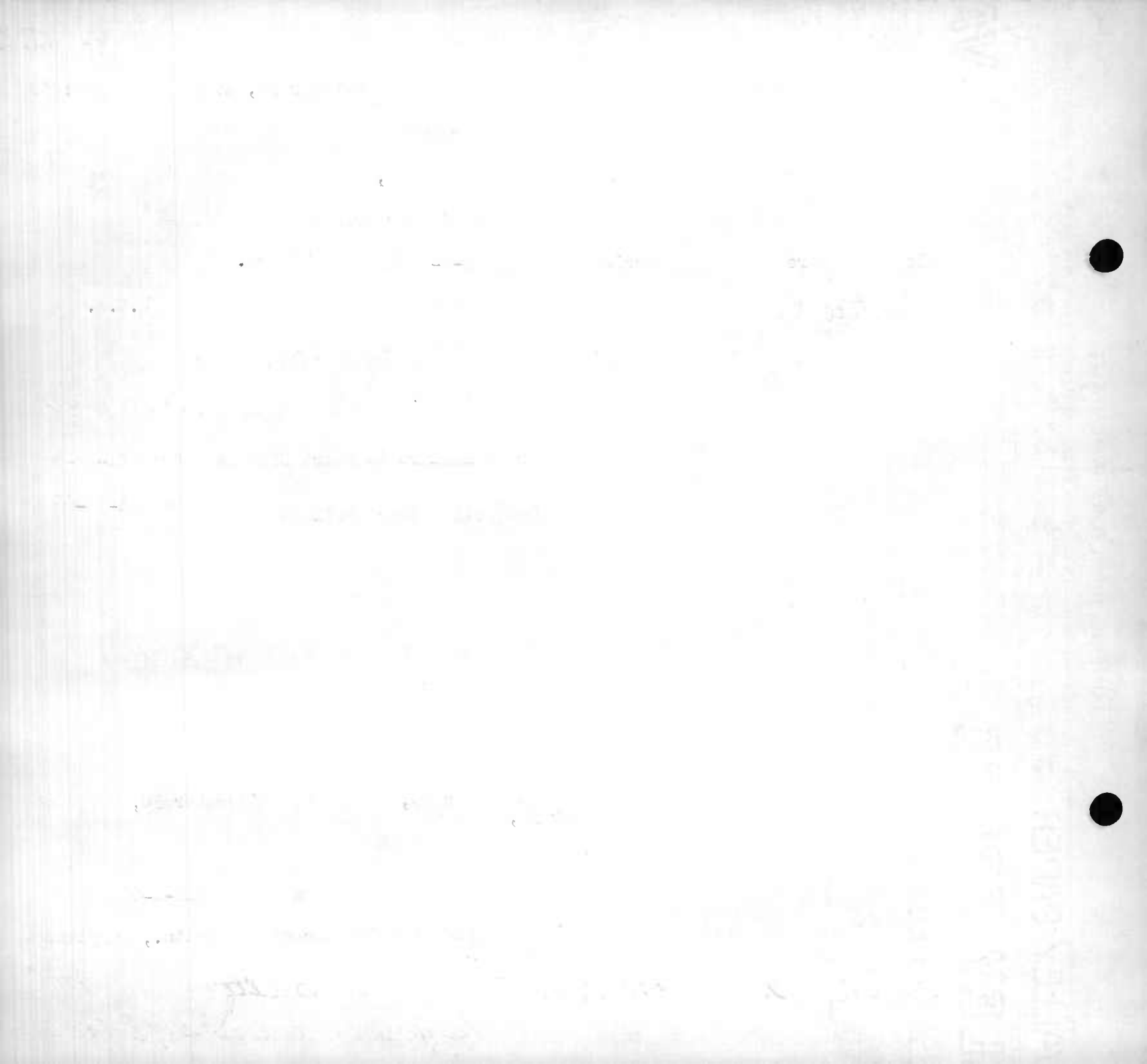
BIRTH NO. <b>66 12183</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12183</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>James J. Dolan</b>		2. DATE AND HOUR OF DEATH <b>12-3-66 11:30 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>4403 Frederick Av. Baltimore Md 21229</b>		D. STREET ADDRESS (If rural, give location) <b>4403 Frederick Avenue 21229</b>		E. CITY OR TOWN (If rural, give township)	
5. SEX <b>M.</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Religious</b>	8. DATE OF BIRTH <b>July 22, 1864</b>	9. AGE (In years last birthday) <b>92</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher (retired)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Religious</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond-Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>James J. Dolan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Collins</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Brother John Edward C.F.X</b>	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>Cardiovascular Disease</b>		(B) DUE TO <b>Arteriosclerosis (Generalized)</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO <b>Heart Failure</b>		(D) DUE TO	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>12-3-66</b> to <b>12-3-66</b> and that (I) (we) last saw the deceased alive on <b>12-3-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Alfredo Aldave M.D.</b>	
23B. DATE SIGNED <b>12-3-66</b>		23C. PHYSICIAN'S NAME (Type) <b>Alfredo Aldave M.D.</b>		23D. ADDRESS <b>6411 Frederick Rd. Baltimore Md. 21228</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-7-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart Hospice Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Leonardtown, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fajal</b>	
25C. FUNERAL DIRECTOR <b>W. E. Evans &amp; Son, Inc</b>		25D. ADDRESS <b>8802 Hayfield Rd - Balts.</b>		25E. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1966</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 12184		CERTIFICATE OF DEATH		Registered No. 66 12184	
1. NAME OF DECEASED <b>Joseph Johnson</b>				2. DATE AND HOUR OF DEATH <b>November 30, 1966 8:45 PM.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>28-31</b> D. STREET ADDRESS (If rural, give location) <b>3804 Fear Avenue</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-6-1891</b>		9. AGE (In years last birthday) <b>75 yrs.</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Johnson</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mattie Johnson Wife</b>			
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Arteriosclerotic Heart Disease</b> DUE TO (B) <b>Congestive Heart Failure</b> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <b>From 11-29-66 To 11-30-66</b>	
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>November 29, 1966</b> to <b>November 30, 1966</b> , that (I) (we) last saw the deceased alive on <b>November 30, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE  <b>Amir</b>						M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-1-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Amir</b>				23D. ADDRESS M.D. <b>1514 Division Street Balto., Maryland</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-6-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto National Em.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Rayner Sanders</b>		ADDRESS <b>217 E. Preston St</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 12185		66 12185	
BIRTH NO.				66 12185			
NAME CASE NO.				66 12185			
1. NAME OF DECEASED (Type or Print) <i>Oliver Sturgis</i>				2. DATE AND HOUR OF DEATH <i>12-3-66</i> <i>5:30 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bolton Hill Nursing Home</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore, Md. 21218</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>12-04</i> D. STREET ADDRESS (If rural, give location) <i>420 East 23rd Street</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>9-14-1948</i>	9. AGE (In years lost birthday) <i>68 yrs.</i>	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Gloster, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Isabel Sturgis</i>			14. MOTHER'S MAIDEN NAME <i>Emaline Lockley</i>			<i>Gloster, Va.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <i>332X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>cerebral thrombosis</i> DUE TO (B) <i>cerebral arteriosclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i> <i>several yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-24-</i> <i>19 66</i> to <i>12-3-66</i> <i>19</i> that (I) (we) lost saw the deceased alive on <i>12-3-66</i> <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. Ellsworth Cook</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12-3-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. ELLSWORTH COOK</i>				23D. ADDRESS M.D. <i>2431 Maryland Avenue</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-7-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 6 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Rayner Sanders</i>		ADDRESS <i>217 E Preston St</i>	

10/1/1917  
The following is a list of the  
names of the persons who have  
been appointed to the various  
positions in the office of the  
Commissioner of the General  
Land Office, Department of the  
Interior, Washington, D. C.

1. Mr. J. H. ...  
2. Mr. ...  
3. Mr. ...  
4. Mr. ...  
5. Mr. ...  
6. Mr. ...  
7. Mr. ...  
8. Mr. ...  
9. Mr. ...  
10. Mr. ...

Very respectfully,  
J. H. ...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 12186	
BIRTH NO. 66 12186		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CARRIE MCDONALD</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 1-1966 1130 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1039 W. Fayette St</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1802</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1039 W. Fayette St.</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Portsmouth VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward White</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lassiter</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lillie Wiley</b> ADDRESS <b>1039 W. Fayette St</b>			
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/29</b> 19 <b>57</b> to <b>5/1</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>5/1</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ralph W. Reckling</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/5/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ralph W. Reckling</b>				23D. ADDRESS <b>1401 A Edmondson Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>12/6/66</b>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>PORTSMOUTH VA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Marjorie P. Hays</b>		ADDRESS <b>638 N. GILMOR</b>	

General info/10

Memphis 10/10/10  
Fort Worth 10/10/10

1  
C 621  
C-710

BIRTH NO. 66 12187		BALTIMORE CITY HEALTH DEPARTMENT		66 12187	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. _____	
1. NAME OF DECEASED (Type or Print) <b>KENNETH CROSBY (Cosby)</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>December 4, 1966 1:20 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1326 Aisquith Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>Nov 11, 1939</b>	9. AGE (In years last birthday) <b>27</b>	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balti. Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Jesse Cosby</b>			
14. MOTHER'S MAIDEN NAME <b>Lucille Booth</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lucille Cosby, 1326 Aisquith St</b>			
18. CAUSE OF DEATH <b>330X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Ruptured Cerebral Aneurysm</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertensive and Arteriosclerotic Cardiovascular</b>		INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/5/66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>Dec 4/66</b>		23C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cem</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		24C. FUNERAL DIRECTOR <b>Motor E. Eliseon</b>	
24D. LOCATION (City, town, or county) (State) <b>Waltport Md.</b>		24E. ADDRESS <b>129 N. Carroll St.</b>			

(3-10)

Nov. 1939

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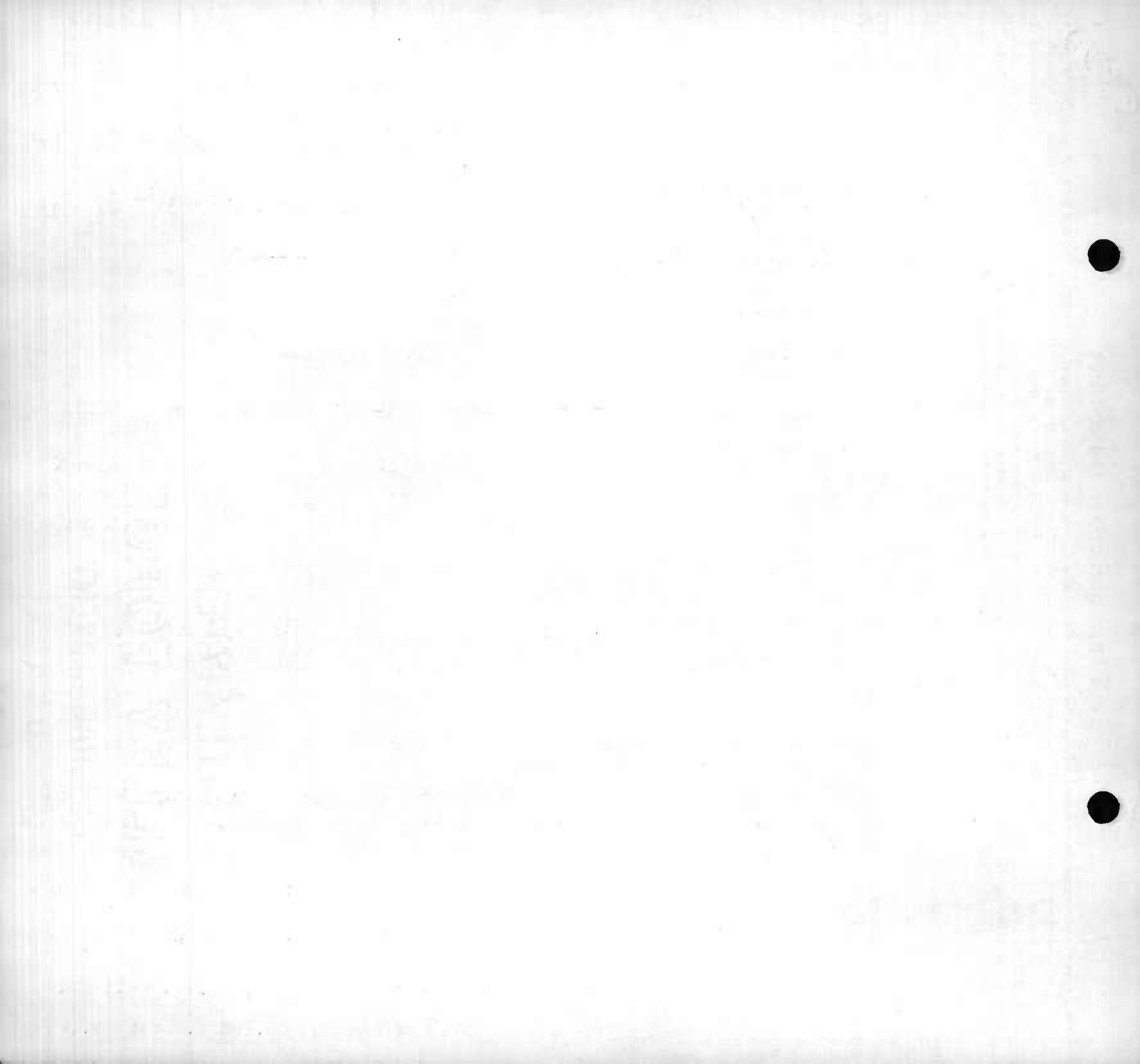


BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

BIRTH NO. 66 12188		2. DATE AND HOUR OF DEATH Dec 4 1966 8:45 A.M.	
M.E. CASE NO.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
1. NAME OF DECEASED (Type or Print) Hong Chin		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) Hospitals 4940 Eastern Avenue, Baltimore City 21224			
5. SEX Male	6. RACE Yellow Oriental	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1886
9. AGE (In years last birthday) 77-80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laundryman	
11. BIRTHPLACE (State or foreign country) China		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Chin Yung		14. MOTHER'S MAIDEN NAME YKK Toy Shee	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-34-3063	
17. INFORMANT Records: BCH-4940 Eastern Avenue		ADDRESS 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia		INTERVAL BETWEEN ONSET AND DEATH one week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Urinary Tract Infection two weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Right Cerebrovascular Accident 10 yrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about 21C. WHERE DID home, farm, factory, street, office bldg., INJURY OCCUR? (If in Baltimore City, give exact location))	
21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 25 1965 to December 4 1966, that (I) (we) last saw the deceased alive on December 4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joseph Silva		23B. DATE SIGNED Dec 4, 1966	
23C. PHYSICIAN'S NAME (Type) Joseph Silva		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/66	
24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK CEMETERY		24D. LOCATION (City, town, or county) (State) WOODLAWN, BALTO. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1966		25B. NAME OF REGISTRAR STEWART & JOWEN CO.	
25C. FUNERAL DIRECTOR STEWART & JOWEN CO.		ADDRESS 108 W. North Av., City	

FUNERAL DIRECTOR: IMPORTANT

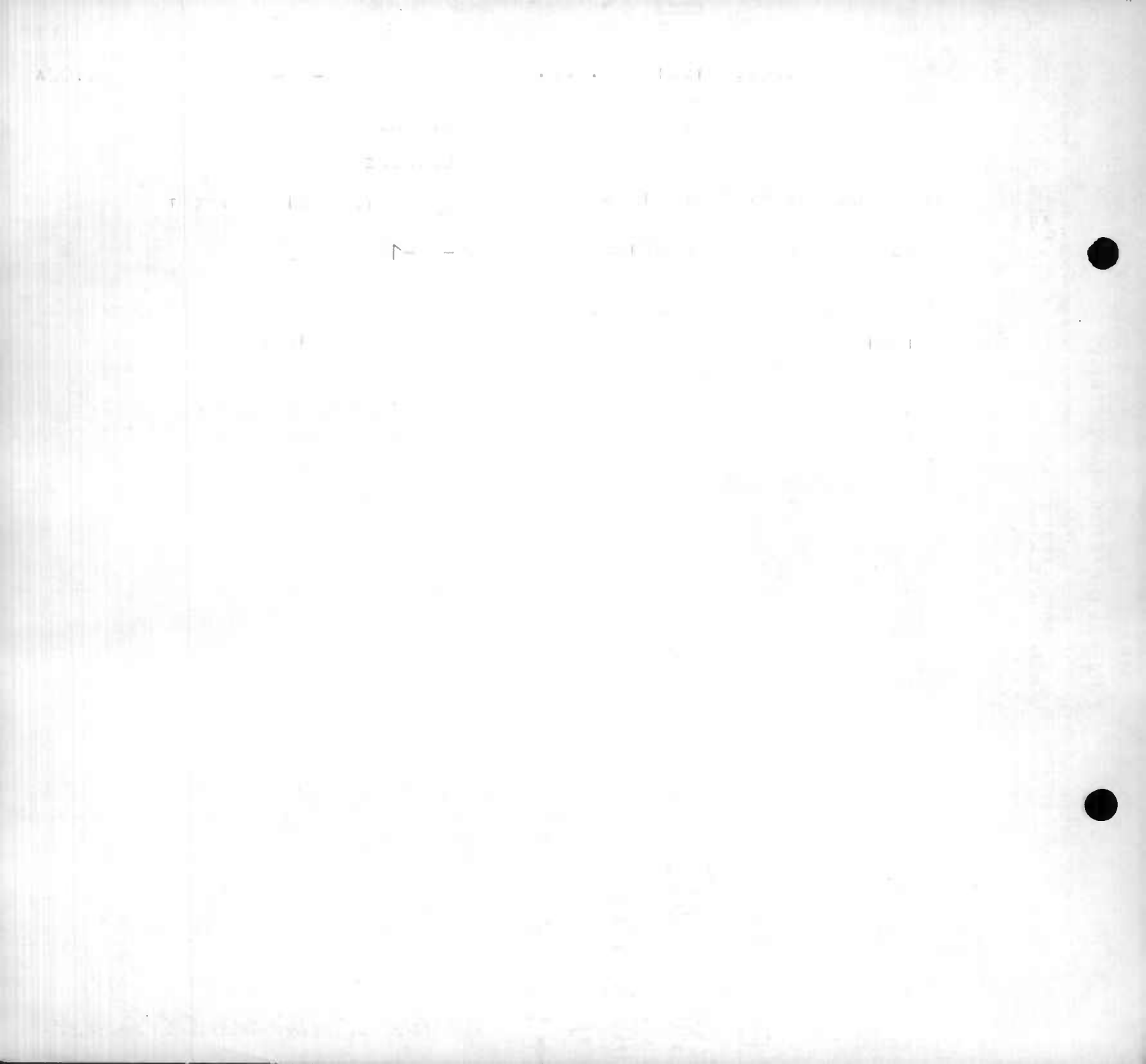
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY, MARYLAND DEPARTMENT OF HEALTH											
BIRTH NO. 66 12189											
CERTIFICATE OF DEATH											
Registered No. 66 12189											
1. NAME OF DECEASED (Type or Print) <b>COLE, WILLIAM E. JR.</b>						2. DATE AND HOUR OF DEATH <b>12-04-66 6:00A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 10-01</b> D. STREET ADDRESS (If rural, give location) <b>1226 NORTH SPRING STREET</b>					
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED, NEVER MARRIED <b>MARRIED</b>		8. DATE OF BIRTH <b>11-30-06</b>		9. AGE (in years last birthday) <b>50</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Shoes</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM Cole</b>						14. MOTHER'S MAIDEN NAME <b>REBECCA CUMMINGS</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W.W. II</b>				16. SOCIAL SECURITY NO. <b>218-05-4399</b>		17. INFORMANT ADDRESS <b>Delphine Cole 1226 N. Spring St.</b>					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>a month</b>											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>Nov 11 19 66</b> to <b>Dec 4 19 66</b> , that (1) (we) last saw the deceased alive on <b>6 AM Dec 4 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Tah-Hsiung Hsu</b>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>12/4/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>TAH-HSIUNG Hsu</b>						23D. ADDRESS M.D. <b>The Johns Hopkins Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>12-7-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>National Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1966</b>				25B. NAME OF REGISTRAR <b>R. E. Taylor</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Randolph Woodcock 2431 E. Oliver St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">66 12190</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">66 12190</span>		<b>CERTIFICATE OF DEATH</b>			
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">JOHN O. DEACON</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">12-6-66 255 a</span> M.			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <span style="font-size: 1.5em;">48</span> </div> <div style="width: 50%;">                     (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">MARYLAND GEN'L Hosp</span>  <span style="font-size: 1.2em;">HOWARD &amp; MADISON</span>  <span style="font-size: 1.2em;">BALTO. MD</span> </div> </div>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">21224</span> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">BALTO.</span> <b>D. STREET ADDRESS</b> (If rural, give location) <span style="font-size: 1.2em;">3433 E. BALTIMORE ST.</span>			
<b>5. SEX</b> <span style="font-size: 1.5em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.5em;">W</span>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">WIDOWED</span>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">4-27-84</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">82</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">BTH. STEEL</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Steel Worker</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">MD</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">CHARLES DEACON</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">MARY C. GEYER</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">213 07 8743A</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">MARY DEACON - ABOVE</span>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) <span style="font-size: 1.2em;">COMPLICATIONS OBSTRUCTIVE</span> DUE TO <span style="font-size: 1.2em;">CHOLELITHIASIS - cholecystic fistula</span> (B) DUE TO _____ (C) _____			
<b>INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">- 2 months</span>		<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <span style="font-size: 1.2em;">II</span>			
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">11-15-66</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">cholelithiasis - obstructive</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <span style="font-size: 1.2em;">No</span>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <span style="font-size: 1.2em;">No</span>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">No</span>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">No</span>		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <span style="font-size: 1.2em;">No</span>	
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <span style="font-size: 1.2em;">No</span>			
<b>22. I certify that (he) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11-11</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">12-6</span> 19 <span style="font-size: 1.2em;">66</span>.</b> <b>that (he) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12-5</span> 19 <span style="font-size: 1.2em;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Gary Lee Nobel</span> M.D.		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">12-6-66</span>		<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">GARY LEE NOBEL</span>	
<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">2309 A Anclona Ct. MD</span>		<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>			
<b>24B. DATE</b> <span style="font-size: 1.2em;">12/9/66</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Oak Lawn Cemetery</span>		<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">DEC 6 1966</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">John A. Moran, Inc.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">3000 E. Balto. St</span>	

30-3-20

1  
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66 12191

BALTIMORE CITY HEALTH DEPARTMENT

66 12191

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RIVAS JENNIE A. RIVAS

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966 11:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home &amp; Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

725 S. Broadway

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 24, 1895

9. AGE (In years  
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Puerto Rico

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Alcaraz

14. MOTHER'S MAIDEN NAME

Barbara

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Peter Rivas 723 S. Broadway

ADDRESS

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease  
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-9-66

23C. NAME of CEMETERY or CREMATORY

St. Raymonds

23D. LOCATION

Bronx, New York

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 6 1966

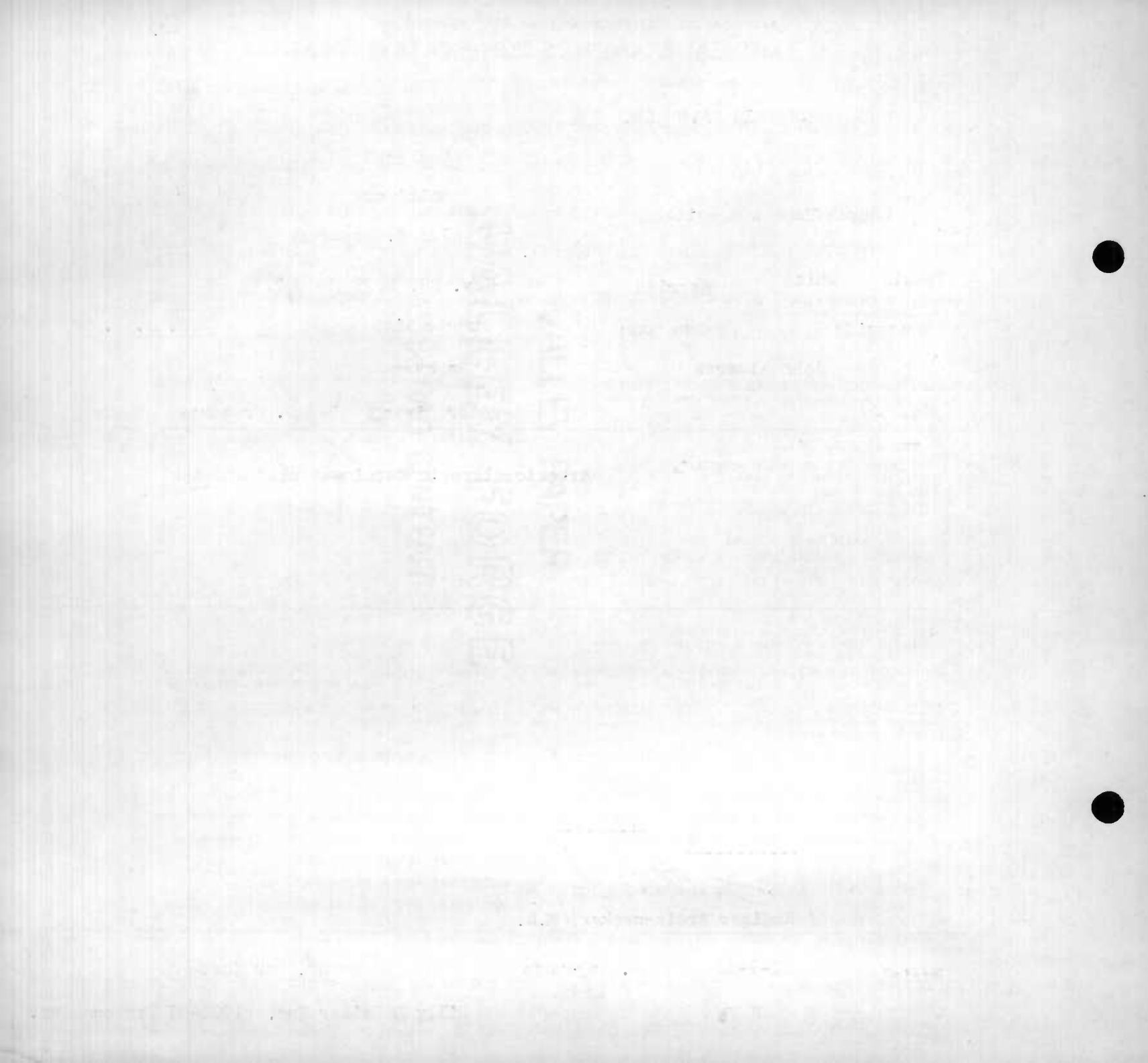
24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave

ADDRESS





1  
E-524 66 12192

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12192

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DR. SAMUEL M. ENGLISH		2. DATE AND HOUR PRONOUNCED DEAD December 4, 1966 9:50 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 223 Wendover Road		5. AGE (In years last birthday) 78	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June 13, 1888	9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Medical & Surgical Director		10B. KIND OF BUSINESS OR INDUSTRY B&O RR		11. BIRTHPLACE (State or foreign country) Landisburg, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James English		14. MOTHER'S MAIDEN NAME Amelia Kochenderfer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 089-RR-Ret.		17. INFORMANT 3026 Cadillac Dr. George English Cedar Falls, Iowa	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/5/66 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify) Entombment		23B. DATE 12/7/1966		23C. NAME of CEMETERY or CREMATORY Greenmount Mausoleum	
23D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24A. DATE REC'D BY HEALTH DEPT. DEC 6 1966		24B. NAME OF REGISTRAR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 12193	
M-1-135				66 12193	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Rudolf F. Martin				12-5-1966 1 6 40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
Union Memorial Hospital 44				Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4627 Walther Boulevard	
5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 5-28-1915	
Insurance Agent		Insurance		9. AGE (In years last birthday) 51	
13. FATHER'S NAME Fritz Otto Martin		14. MOTHER'S MAIDEN NAME Erna Weinschenk		11. BIRTHPLACE (State or foreign country) Germany	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216012099		12. CITIZEN OF WHAT COUNTRY? USA	
17. INFORMANT Mrs Frances T. Martin				ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes Mellitus	
20A. AUTOPSY? (Yes or No) 0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/12/66 to 12/5/66, that (I) (we) last saw the deceased alive on 11/25/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anderson M. Renick				23B. DATE SIGNED 12/5/66	
23C. PHYSICIAN'S NAME (Type) ANDERSON M. RENICK				23D. ADDRESS 1010 34. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12-9-66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION Baltimore, Md.		24E. STATE (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1966		25B. NAME OF REGISTRAR R. E. Fisher		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.	

ANDERSON W. BENICK

1903 24 June 24

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12194</u>	
BIRTH NO. <u>60 12194</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>ANTOINETTE PATTERSON</u>		<u>11-3-66</u> <u>1:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33 BALTIMORE, MD 21205</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>DORCHESTER Co.</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>CAMBRIDGE</u>			
		D. STREET ADDRESS (If rural, give location) <u>715 DOUGLAS STREET</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>5-29-66</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days <u>5</u> <u>5</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign, country) <u>Cambridge, Md</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>CHELSEA BANKS</u>			14. MOTHER'S MAIDEN NAME <u>KATHRYN PATTERSON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Kathryn Patterson</u>		ADDRESS <u>Cambridge</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <u>754.51</u> <u>CONGENITAL HEART DISEASE</u> <u>(Tricuspid atresia)</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 mo</u>	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>11/2/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Tricuspid atresia</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>10/13/66</u> to <u>11/3/66</u> and that (I) <u>lost</u> saw the deceased alive on <u>11/3 12pm</u> 19 <u>66</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Jerry S. Dorman</u>				23B. DATE SIGNED <u>11/3/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jerry Dorman</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<u>Burial</u>		<u>11/5/66</u>		<u>Rock Creek</u>	
24D. LOCATION (City, town, or county)		24E. STATE			
<u>Cambridge, Md</u>		<u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<u>DEC 6 1966</u>		<u>Reese, E. E.</u>		<u>Booker M. West</u>	
				ADDRESS <u>Salisbury</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12195</b>	
BIRTH NO. <b>66 12195</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Ellis Roland Deans</b>		2. DATE AND HOUR OF DEATH <b>December 1, 1966</b>   <b>2: a.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2532 McCulloh Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>April 26, 1902</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia (Portsmouth)</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Deans</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Connor</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>B-214-40-5201</b>		17. INFORMANT <b>Elmer W. Deans-wife</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANCECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cerebral hemorrhage - right</b> DUE TO <b>hemiplegia</b> (B) <b>hypertension, essential</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>11-29 thru 12-1-1966</b> <b>6+ years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 29, 1966</b> to <b>December 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 1, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James D. Carr</b>				23B. DATE SIGNED <b>December 1, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES D. CARR</b>				23D. ADDRESS <b>1514 Division Street-Baltimore 17, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/5/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus Balto Co. Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1966</b>			
25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3035 W. North Ave</b>			

Division of  
Laboratory  
Investigation

Washington

March

April 1, 1934

(Circular)

100

Division of

Investigation

100

Division of  
Laboratory  
Investigation

100

Division of



1  
L-516

66 12196

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12196

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

STANLEY T LAMBROS

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966 2:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4307 Springwood Avenue #6

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5-29-1907

9. AGE (In years  
last birthday)

66-59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

hard

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Lambros

14. MOTHER'S MAIDEN NAME

Helen Karafotis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-09-0515

17. INFORMANT

ADDRESS

Mrs Evelyn D. Lambros 4307 Springwood Av

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Burial

12-7-1966

Greek Community Church Cem. Baltimore

DEC 7

1966

Robert E. Fairley

Joseph Funeral Home 7401 Belair Road

WILSON  
JAN 14 1906  
FORD  
FORD

66 12197

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12197

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES E.

BROCKLEHURST Sr.

2. DATE AND HOUR PRONOUNCED DEAD

December 1, 1966

1:15 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

35 Church Home &amp; Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

426 N. Lakewood Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 3, 1911

9. AGE (In years  
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Postman

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Govt.

11. BIRTHPLACE (State or foreign country)

Terra Haute, Indiana

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Brocklehurst

14. MOTHER'S MAIDEN NAME

Está Edmundson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

WWII &amp; Korean

16. SOCIAL  
SECURITY NO.

216-07-0734

17. INFORMANT

ADDRESS

Clara Brocklehurst 426 N. Lakewood Avenue

18.

E981X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Gunshot wound of Chest with perforation  
of Heart

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

426 N. Lakewood Avenue

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
12 1 '66 12:45A

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Was shot in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-5-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 7 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

John C. Miller Inc.

ADDRESS

-415 Belair Rd. -21206

W. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
66 12198		66 12198			
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MCFADDEN, ESTON EARL		December 5, 1966		9:50 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		Maryland		Balto Co.	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male	Caucasian	Divorced			
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
8/1/97		69		Mechanic	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Maryland		United States		William J. MCFadden	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Laura Henry		Yes 4/1/17-5/13/19		213-18-01-28	
17. INFORMANT		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION	
Hospital Records, VAH Balto., Md.		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH two weeks	
		(A) Respiratory failure DUE TO Chronic Obstructive Pulmonary Disease (B) DUE TO (C)			
20. A. DATE OF OPERATION		20. B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. A. AUTOPSY? (Yes or No)	
				No	
21. A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21. B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21. C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21. D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21. E. INJURY OCCURRED		21. F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from October 6, 1966 to December 5, 1966, that (X) (we) last saw the deceased alive on December 5, 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23. A. SIGNATURE				23. B. DATE SIGNED	
John F. Habener, M.D.				December 5, 1966	
23. C. PHYSICIAN'S NAME (Type)		23. D. ADDRESS			
JOHN F. HABENER, M.D.		Veterans Hospital 3900 Loch Raven Blvd, Baltimore, Md. 21218			
24. A. BURIAL CREMATION REMOVAL (Specify)		24. B. DATE		24. C. NAME OF CEMETERY or CREMATORY	
Burial		8 Dec 66		Druid Ridge Cem	
24. D. LOCATION (City, town, or county) (State)		24. E. DATE REC'D BY HEALTH DEPT.		24. F. NAME OF REGISTRAR	
Pikesville, Balto Co, Md		DEC 7 1966		Ruth E. Habener	
24. G. FUNERAL DIRECTOR		24. H. ADDRESS		24. I. ADDRESS	
Burdgee Funeral Home		3631 Falls Rd/B		Nellie M. Burdgee	

John F. Thompson

General 8200e Green Bay, Wis. 54301  
Business Development Dept.

October 2, 1964  
Dear Sir:

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 12199		66 12199		66 12199	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
Anna A. Barnes		Dec. 5, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
001427 W. 36th St.		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1427 W 36th St			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days
Female	White	Widowed	March 21, 1880	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
At home		—	Maryland	U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
William Henry Burns		Mary Melvin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
No			Earl M. Barnes		1427 W 36th St
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 I		Atherosclerotic cardio-vascular disease		10 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		B. DUE TO			
		C. DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Cackles due to interstitial emphysema		6 mos	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 19 47</u> to <u>Dec 5 19 66</u> , that (I) (we) last saw the deceased alive on <u>Nov 25 19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D.	Attending Phys. <input checked="" type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input type="checkbox"/>
Frederick J. Vollmer					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23B. DATE SIGNED	
Frederick J. Vollmer		6100 York Rd Baltimore Md		Dec 6, 1966	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	8 Dec 66	Woodlawn Cem		Woodlawn, Balto Co, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 7 1966		Robert E. Farkas		Burdgee Funeral Home 3651 Falls Rd Bal	

1427 64 32m 47  
Tomb white  
1st home  
William Henry Barnes  
No

1427 64 32m 47  
March 1895 24  
Maryland  
Mary Melvin  
Earl M. Barnes was born

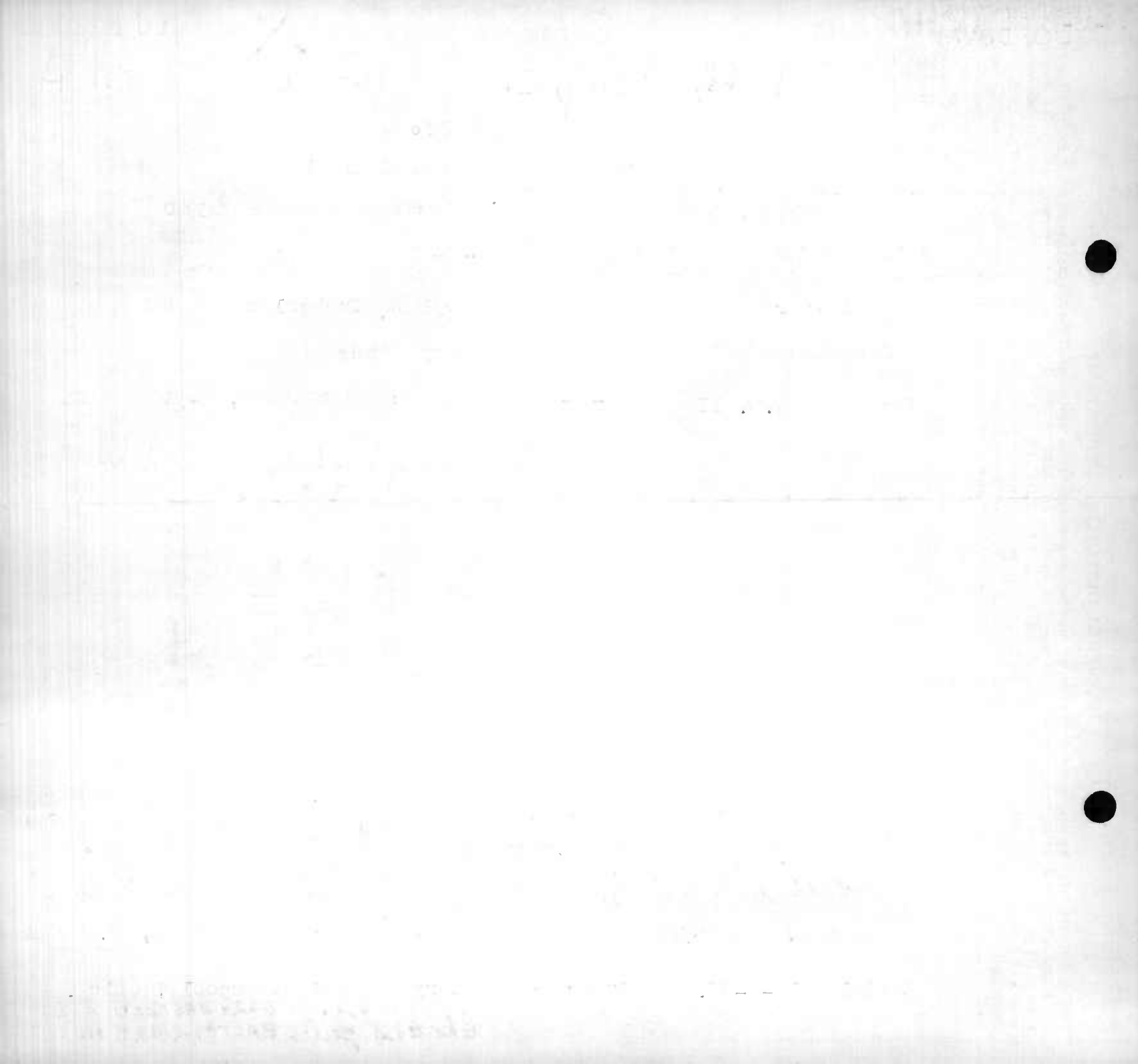
Born 1895 at Woodbury Conn  
Frederick A. Volkmann  
New York City



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

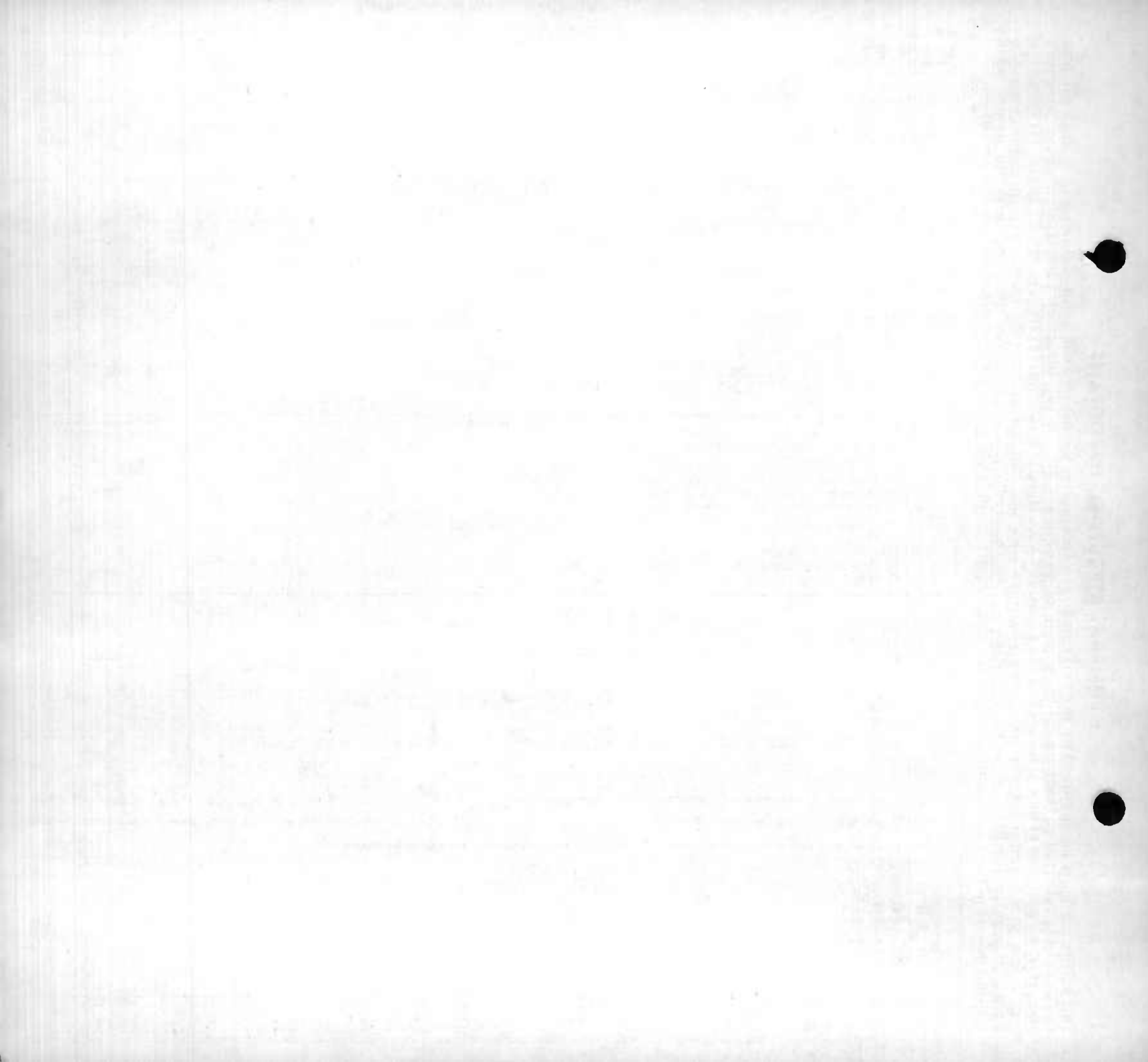
BIRTH NO. 66 12200		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>Dahl, Harry, C.</b>		2. DATE AND HOUR OF DEATH <b>12-4-66 3:33 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>		A. STATE <b>Ohio</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>East Liverpool</b> D. STREET ADDRESS (If rural, give location) <b>511 Wedgewood Avenue #43920</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify) Divorced</b>	8. DATE OF BIRTH <b>9-15-25</b>
9. AGE (In years last birthday) <b>41</b>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steelworker</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland, Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John William Dahl</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wade</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W. II</b>		16. SOCIAL SECURITY NO. <b>219-14-7103</b>	
17. INFORMANT <b>RECORDS: BCH Baltimore, Maryland #21224</b>		ADDRESS	
18. <b>465 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Pulmonary Embolus</b> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-21</b> to <b>12-4</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>12-4</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>David J. Mischelevich</b>		23B. DATE SIGNED <b>12-4-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>David J. Mischelevich</b>		23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Md. #21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-8-66</b>	
24C. NAME of CEMETERY or CREMATORY <b>Riverview Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>East Liverpool, Ohio</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>		25B. NAME OF REGISTRAR <b>Charles E. Jailer</b>	
25C. FUNERAL DIRECTOR <b>6224 EASTERN AVE. BALTO, 21224, MD.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12201</u>	
BIRTH NO. <u>66 12201</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Maude E. Ollinger Lauderdale</u>		2. DATE AND HOUR OF DEATH <u>December 2, 1966</u> <u>1:07</u> <u>P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Gould Convalesarium</u> <u>6116 Belair Road</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>200 W. Seminary Avenue</u> <u>Lutherville, Maryland 21093</u>			
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		8. DATE OF BIRTH <u>March 21, 1875</u> 9. AGE (In years last birthday) <u>91</u>	
13. FATHER'S NAME <u>James Edward Stowe</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family Records</u>	
18. <u>450.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Renal Arteriosclerosis</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>YEAR AGO</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Renal Arteriosclerosis</u> DUE TO			
		(B) <u>Old age</u> DUE TO			
		(C) <u>Congestive Heart Failure</u> DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>None</u>			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>None</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Does Not Apply</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Does Not Apply</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> <u>None</u> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Does Not Apply</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>9 115</u> <u>19 66</u> to <u>11 1 301</u> <u>19 66</u> , that (I) (we) last saw the deceased alive on <u>11 1 301</u> <u>19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles P. Crim</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>12/5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES P. CRIM</u>		23D. ADDRESS <u>2722 E. MONUMENT ST BALTO 5 MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Dec. 5, 1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Memorial</u>	
		24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1966</u>		25B. NAME OF REGISTRAR <u>John Burns</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Sons, Towson, Maryland</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66-25624 66 12202		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 12202	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				JOHN ROBERT COOPER	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		2. DATE AND HOUR OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL</b>		A. STATE <b>MARYLAND</b>		Dec. 3rd. 1966 1.45 A.M.	
(If not in hospital or institution, give street address or location)		B. COUNTY <b>53-00</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
		D. STREET ADDRESS (If rural, give location) <b>100 N. BROADWAY STREET</b>		1709 C. Aberdeen Rd.	
5. SEX <b>M.</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>BABY</b>	8. DATE OF BIRTH <b>Dec. 1st, 1966</b>	9. AGE (In years last birthday) <b>2</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>GARY ROBERT COOPER</b>		14. MOTHER'S MAIDEN NAME <b>MR'S. CARLA COOPER</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Church Home &amp; Hospital. 21231</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>723.5 I</b>		CAUSE OF DEATH (A) DUE TO <b>Hyaline Membrane Disease</b> (B) DUE TO <b>Prematurity</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1st</b> 19 <b>66</b> to <b>Dec. 3rd</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec. 3rd</b> , 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>And Brumm M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5 Dec. 66</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Park</b>	
				24D. LOCATION (City, town, or county) (State) <b>Parkville, Balto. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John Burns Sons Towson, Md.</b>	

1010-1-21-11

CHURCH HOME & HOSPITAL

M. W. BARRY

NAME NONE

ROBERT COOPER

1740-1-11

BALTIMORE

100 N. PEARSON WAY. ST. LOUIS

Dec 1st 1911

MARKLAND ALEXANDER

MRS CARLA COOPER

CHURCH HOME & HOSPITAL

HOSPITAL MEMBERSHIP

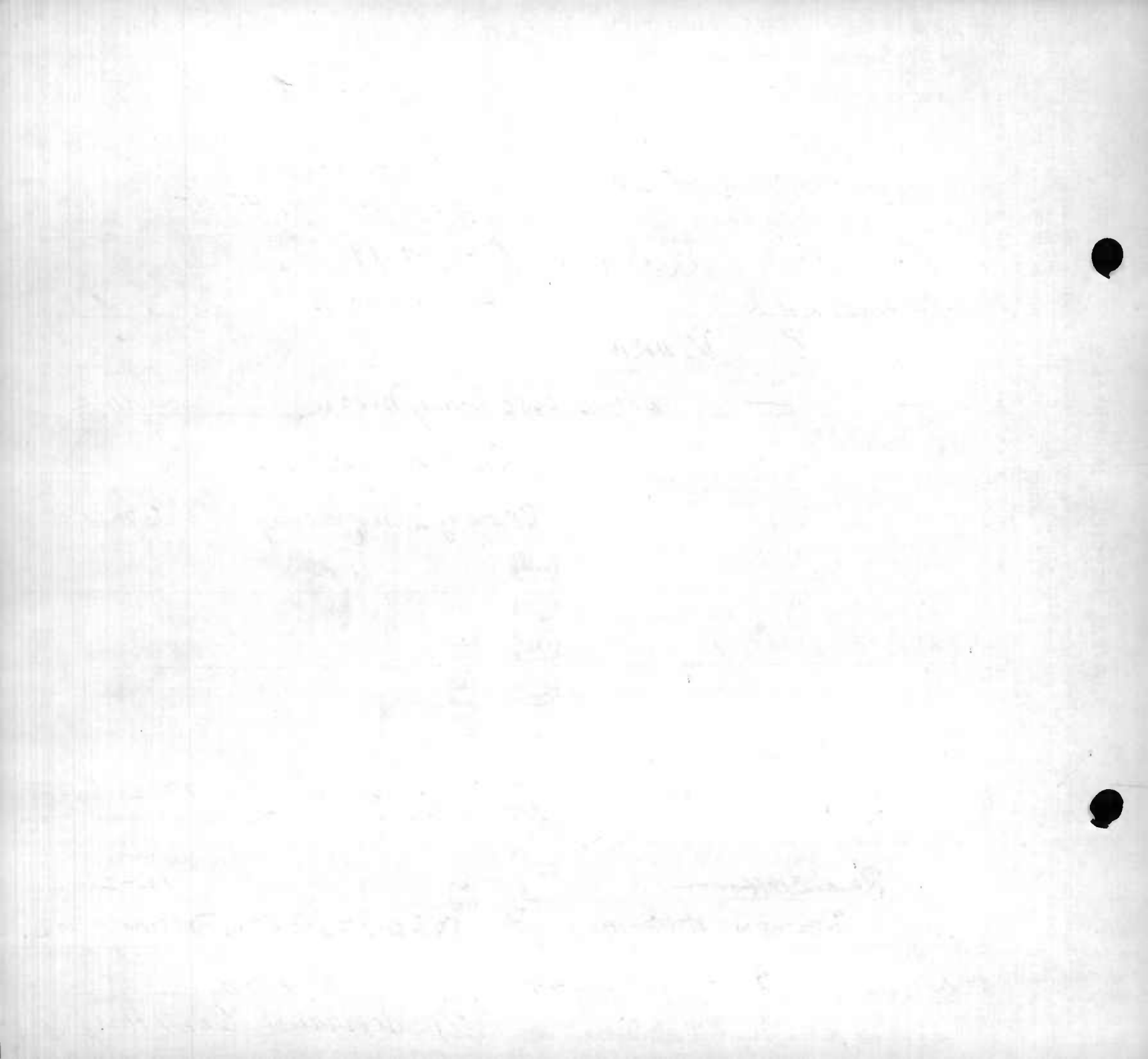
Presenting

Dec 3rd 1911  
Dec 1st 1911  
Dec 3rd 1911

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12203				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12203	
1. NAME OF DECEASED (Type or Print) <i>Anna Nauden</i>				2. DATE AND HOUR OF DEATH <i>Dec 24 1966 3 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 1333 W. 41st St.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>1308</i> D. STREET ADDRESS (If rural, give location) <i>1333 W. 41st St.</i>			
5. SEX <i>F</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>MAY 24 79</i>	9. AGE (In years lost birth day) <i>87</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SEAMSTRESS</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>LITHUANIA</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>? VIDRA.</i>			14. MOTHER'S MAIDEN NAME <i>? </i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>			16. SOCIAL SECURITY NO. <i>217-16-6680</i>		17. INFORMANT <i>Mary Morse</i>		
18. <i>4-20-11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cardiac failure</i>			CAUSE OF DEATH (A) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Coronary insufficiency</i>			(B) DUE TO				
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-18 1966</i> to <i>12-2 1966</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>NOV 19 66</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <i>Reuben Hoffman</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12-2-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>REUBEN HOFFMAN</i>				23D. ADDRESS <i>846 W. 36th St., BALTIMORE, MD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/5/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>MORELAND</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 7 1966</i>		25B. NAME OF REGISTRAR <i>Reuben Hoffman</i>		25C. FUNERAL DIRECTOR <i>Reuben Hoffman</i>		ADDRESS <i>6067 Hayford Rd</i>	





1  
J-520

66 12204

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12204

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT EVERETT JONES

2. DATE AND HOUR PRONOUNCED DEAD

December 2, 1966 4:50 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

442 E. Grindall Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 23, 1920

9. AGE (In years  
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Miscel.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Jones

14. MOTHER'S MAIDEN NAME

Valory Henry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL  
SECURITY NO.

232 26 7300

17. INFORMANT

ADDRESS

Mr. Gourlie Jones Manassas, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Congenital Polycystic Disease of  
~~Kidneys~~  
Kidneys and Liver.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty Liver and Cirrhosis.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/2/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/7/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 7

1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

JOHN F. DENNY, INC. 715 Light St.

RECEIVED

NOV 10 1960

U.S. DEPARTMENT OF AGRICULTURE

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42-70-21 M-252 66 12205

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

66 12205

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

George Mackenzie

2. DATE AND HOUR OF DEATH

12-6-66

3:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND #21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

4940 EASTERN AVENUE - #21224

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
DIVORCED

8. DATE OF BIRTH

6-9-13

9. AGE (In years  
last birthday)

53

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MASSACHUSETTS

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George MacKenzie

14. MOTHER'S MAIDEN NAME

Anna Veaton

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

REC ORDS-BCH-4940 EASTERN AVENUE-21224

18. 00811

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) TUBERCULOSIS

years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Empty

years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-1-66 to 12-6-66, that (I) (we) last saw the deceased alive on 5 Dec 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph J Berman

M.D.

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

1 Dec 66

23C. PHYSICIAN'S NAME (Type)

Dr. Joseph Berman

M.D.

BCH-4940 Eastern Avenue - Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/10/66

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cem

24D. LOCATION (City, town, or county) (State)

A A Co

Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 7 1966

25B. NAME OF REGISTRAR

R. E. Farley

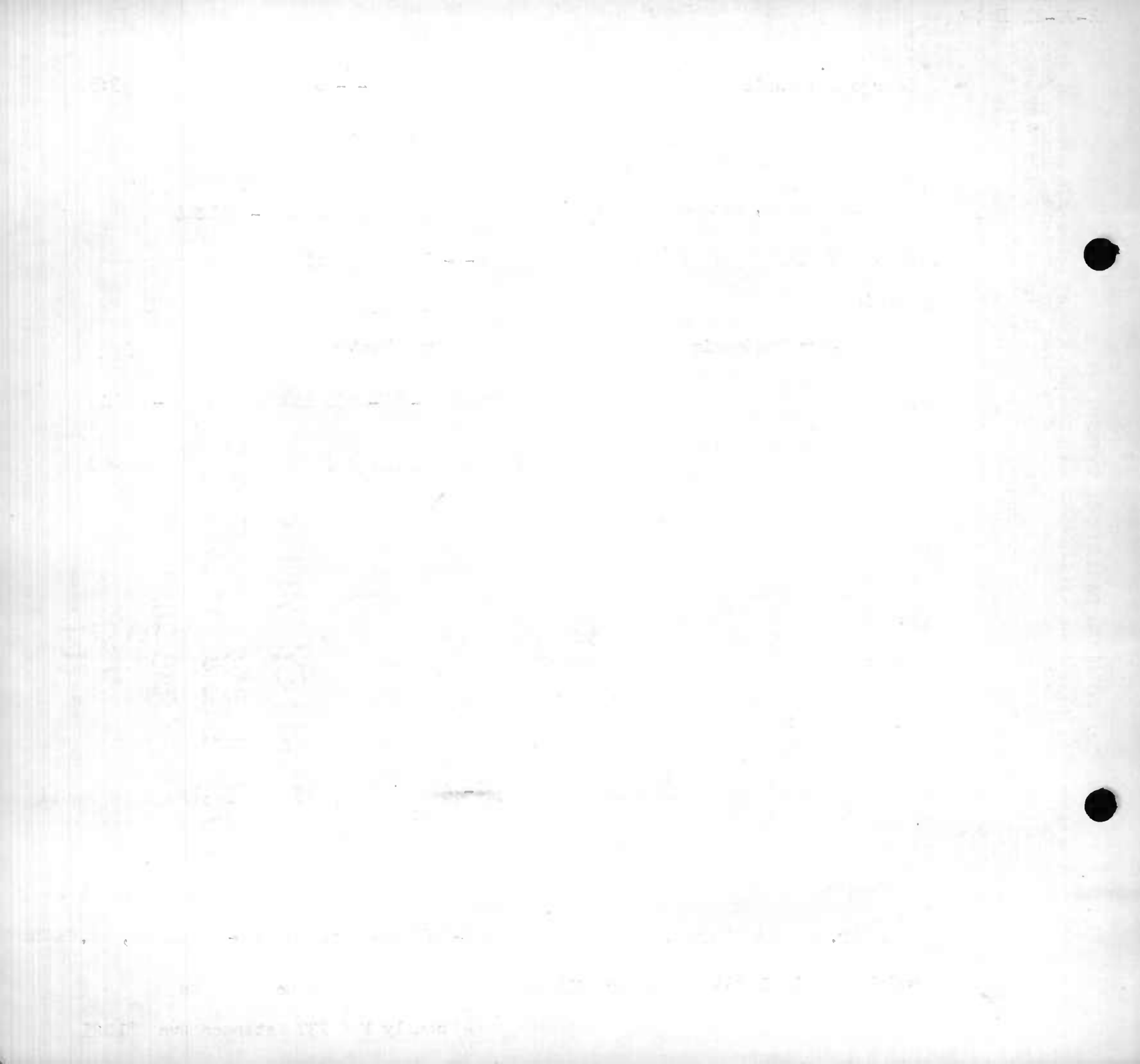
25C. FUNERAL DIRECTOR

McCully F H 237 Patapsco Ave #1225

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12206	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 66 12206</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>HELINSKI, CONSTANCE, J.</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>12-4-66 4:45A M.</b></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVE. BALTO.MD.21229</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>MARYLAND</b> B. COUNTY <b>21224</b></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>7611 BELMONT AVE.</b></p>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>2-17-94</b>	9. AGE (In years last birthday) <b>72</b>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b></p>			<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b></p>
<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>					
<p>13. FATHER'S NAME <b>ANDREW STAHOWIAK</b></p>			<p>14. MOTHER'S MAIDEN NAME <b>FRANCES JAJMAK</b></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b></p>			<p>16. SOCIAL SECURITY NO. <b>212-01-9401D</b></p>		<p>17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL RECORDS CATON &amp; WILKENS AVE. 21229</b></p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>(A) <b>METASTATIC CA TO LUNGS AND RIBS - PRIMARY UNKNOWN -</b></p> <p>(B) DUE TO</p> <p>(C) DUE TO</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <b>NO</b></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>12-1-66</b> to <b>12-4-66</b> that (I) (we) lost saw the deceased alive on <b>12-4-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <b>JUAN J. CABRERA</b> M.D.</p>				<p>23B. DATE SIGNED <b>12-4-66</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>JUAN J. CABRERA</b> M.D.</p>				<p>23D. ADDRESS <b>ST. AGNES HOSPITAL</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>12/7/66</b></p>		<p>24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b></p>	
<p>24D. LOCATION (City, town, or county) <b>Balto md</b></p>		<p>24E. (State)</p>			
<p>25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <b>John J. Connelly Sons, Essex, Md.</b></p>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12207		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 12207	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>FRANK G. JOLLEY</b>			
2. DATE AND HOUR OF DEATH <b>Dec. 5, 1966 12:20 P.M.</b>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital Wyman Pk. Drive &amp; 31st Street</b> 1-10-67				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>DC</b> B. COUNTY <b>Washington</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Washington</b> D. STREET ADDRESS (If rural, give location) <b>490 M Street, SW</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12/18/04</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Telephone Eng.</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank G. Jolley</b>			14. MOTHER'S MAIDEN NAME <b>Lillian Mc Connell</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>?</b>		16. SOCIAL SECURITY NO. <b>514-03-8435</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bilateral bronchopneumonia</b> (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma left lung with cerebral &amp; widespread metastases</b> (B) DUE TO (C) <b>Carcinoma left lung with cerebral &amp; widespread metastases</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Carcinoma left lung with cerebral &amp; widespread metastases</b>				Less than 1 yr.			
19A. DATE OF OPERATION <b>12/6/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 21 19 66</b> to <b>Dec. 5 19 66</b> , that (I) (we) last saw the deceased alive on <b>Dec. 5 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Samuel C. H. Lee</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>12/6/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Samuel C. H. Lee, Surgeon (R)</b> M.D.				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-9-1966</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Martin's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>New Derry, Penna.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. 1217 St. Paul Street Baltimore 2, Maryland</b>			

Bel. 5-3930

January 6, 1967

66-12207  
Called Dr. Samuel C. H. Lee & verified this  
this letter is not on  
Hospital Stationary  
M.H. 1-9-67.

Bureau of Vital Statistics  
Baltimore City Department of Health  
Baltimore, Maryland

Sirs:

Reference is made to the death certificate issued to your office in the case of Frank Glen Jolley who died in the U.S. Public Health Service Hospital, Baltimore 11, Maryland, on December 5, 1966. We wish to advise you that we have revised our records to read:

Immediate cause of death: Bilateral bronchopneumonia

B: Carcinoma left lung with cerebral & widespread metastases.

By direction of the Medical Officer In Charge.

Very truly yours,

Samuel C. H. Lee, M.D.

Samuel C. H. Lee, Sr. Surgeon  
Assistant Chief of Pathology

SCHL/gv

Letter from U.S. Public Health Service Hosp.  
1-10-67 M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12208</u>	
BIRTH NO. <u>66 12208</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mary Belle Hess</u>		2. DATE AND HOUR OF DEATH <u>12/6/66</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balts. Co.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Long Green Nursing Home</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Cockeysville</u>		D. STREET ADDRESS (If rural, give location) <u>None</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Feb. 15, 1873</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milliner</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>WOMENS CLOTHING</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry Hess</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Leister</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-56-3419</u>		17. INFORMANT <u>Armand Shank</u>		ADDRESS <u>12 Matthews Ave. Cockeysville</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerosis</u>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 1966</u> to <u>Dec 1966</u> and that (I) <u>lost</u> saw the deceased alive on <u>5 Dec 1966</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>William G. Helffrich</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12-7-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>William G. Helffrich</u>		23D. ADDRESS M.D. <u>5006 Roland avenue # 21210</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/8/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Sherwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Wm. Cook-Brooks</u>		25C. FUNERAL DIRECTOR <u>Towson 1050 York Rd. 21204</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12209</u>	
BIRTH NO. <u>66 12209</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>66 12209</u>		1. NAME OF DECEASED (Type in Print) <u>Robert Edward Clag</u>		2. DATE AND HOUR OF DEATH <u>11/26/66</u> <u>9</u> <u>P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u> <u>44</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Elkton Co.</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Elkton</u> <u>57-21</u>			
		D. STREET ADDRESS (If rural, give location) <u>307 Landing Loop</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>12/05/00</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Clag</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Heath</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT <u>Eleanor Clag</u> ADDRESS <u>Elkton, Md</u>	
18. <u>451 X1</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>ASCVD</u> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Post Resection Aortic Aneurysm (6 days)</u> DUE TO			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>11/20/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Abdomin Aortic Aneurysm</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (If (this hospital) attended the deceased from <u>11/20/66</u> 19 <u>66</u> to <u>11/26/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/26/66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles H. Classen, Jr.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/26/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES H. CLASSEN, JR.</u>		23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>Nov. 30, 1966</u>	24C. NAME OF CEMETERY or CREMATORY <u>Elkton Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Elkton Cecil, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fick</u>		25C. FUNERAL DIRECTOR <u>Wick Home Funerals, Elkton, Md.</u>	

CLASS H. CLASSE, J.

THE WILSON HOSPITAL

Charles M. Blum

11/30/56

11/30/56

11/30/56 Addendum to the program NO

ASCVD

Post Restoration Post-Operative

Elmer Chap

Rechel Hathi

Handland

USA

Male Cancer Research

12/20/56

307 Landing

Elkton

Handland

Union Memorial Hospital

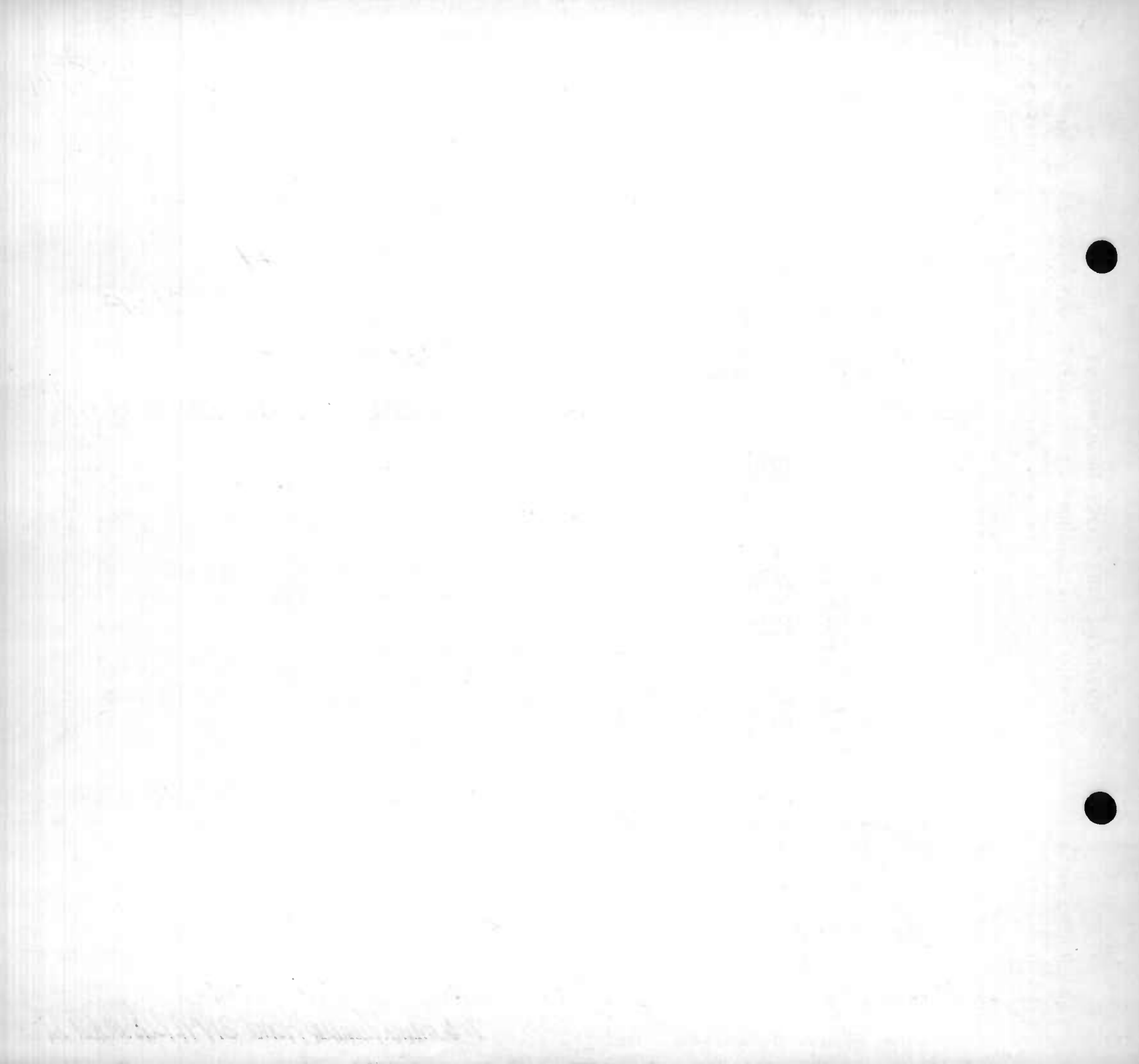
Handland Chap

11/30/56

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12210		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12210	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>DAZELLA K. Bumpers</b>			2. DATE AND HOUR OF DEATH <b>12/3/66 11:15 PM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 20-02</b>		
(If not in hospital or institution, give street address or location)			D. STREET ADDRESS (If rural, give location) <b>2846 Mulberry ST</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>8/14/25</b>	9. AGE (In years last birthday) <b>41</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen Worker</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			13. FATHER'S NAME <b>George Kittrell</b>		
14. MOTHER'S MAIDEN NAME <b>Lizzie Baker</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>238-36-2835</b>			17. INFORMANT <b>George Kittrell 1688 Dorsey Ave.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Amyloidosis</b> (B) <b>Nephrotic Syndrome</b> (C)			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/3/66</b> 19 to <b>12/3/66</b> 19 that (I) <del>was</del> last saw the deceased alive on <b>12/3/66</b> 19 and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>We</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Brian J. Baldwin</b>				23B. DATE SIGNED <b>12/3/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Brian J. Baldwin</b>				23D. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/7/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balt., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		25D. ADDRESS <b>3197 Schroeder St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12211		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12211	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SADIE C. WHITE</b>		2. DATE AND HOUR OF DEATH <b>12-3-66 10<sup>10</sup> AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>		A. STATE <b>MD</b>		B. COUNTY <b>None</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21201</b>			
		D. STREET ADDRESS (If rural, give location) <b>208 N. FREMONT AVE</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>2-7-1903</b>	9. AGE (In years lost birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
13. FATHER'S NAME <b>JOHN JENKINS</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH DORSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>(M/65) 220-30-0802</b>		17. INFORMANT <b>Joseph Magon</b>	
				ADDRESS <b>107 N. Schroeder St</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>157X I</b>		CAUSE OF DEATH <b>Carcinoma of Pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>8/4/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Anorexia &amp; jaundice</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 24</b> 19 <b>66</b> to <b>Dec 3</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-3</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. W. WAGGER</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12-3-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>G. W. WAGGER</b>		23D. ADDRESS <b>UNIVERSITY HOSP. BALTO. 21201</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/7/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>		25B. NAME OF REGISTRAR <b>R. E. E. Foster</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>	
				ADDRESS <b>3199 Schroeder St.</b>	

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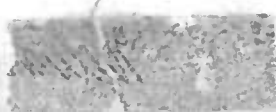
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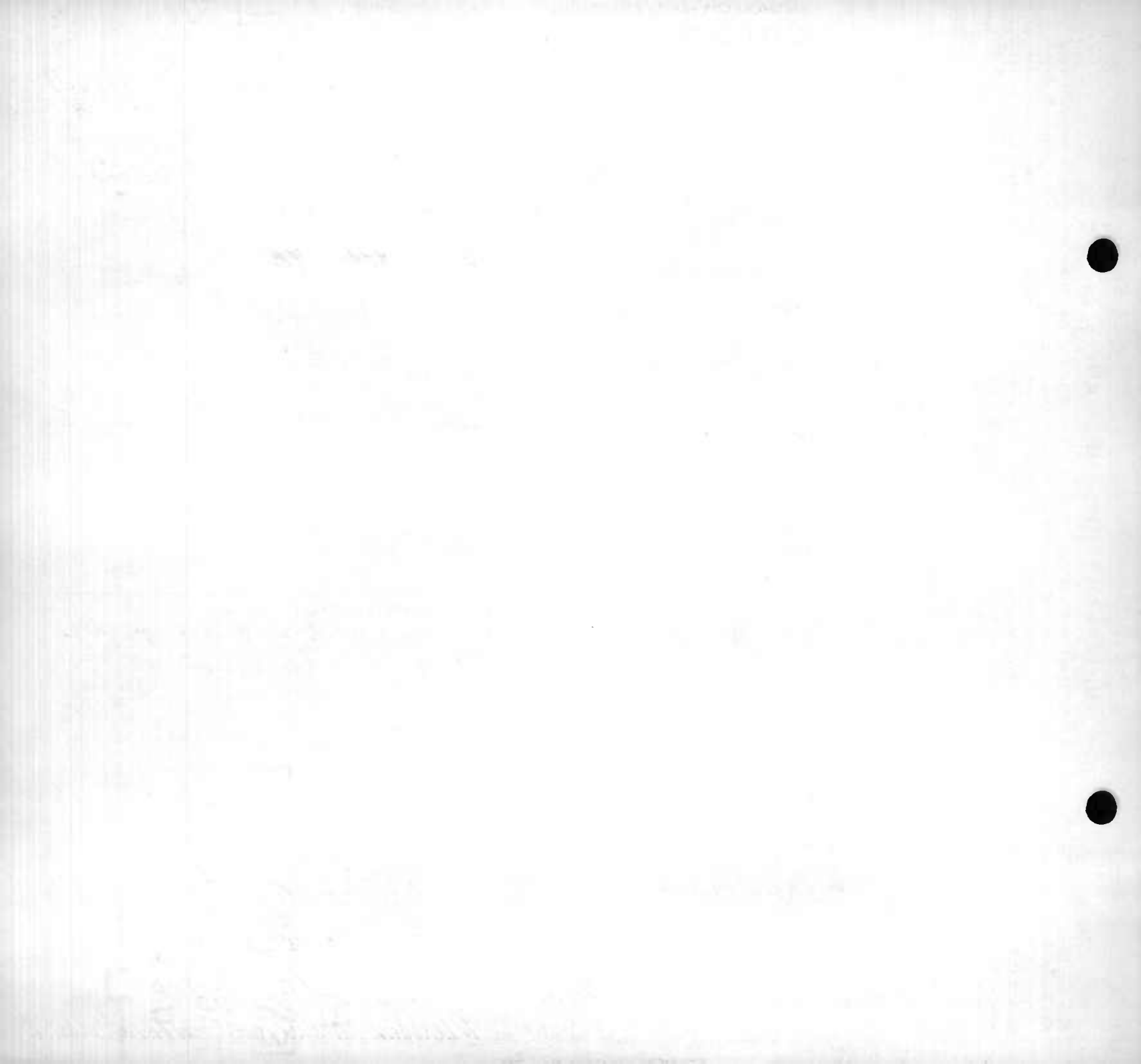




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12212</u>	
BIRTH NO. <u>66 12212</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mary E. Johnson</u>		2. DATE AND HOUR OF DEATH <u>12-6-66</u> <u>4:10 A.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 South Baltimore General Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>25-32</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>21225</u> D. STREET ADDRESS (If rural, give location) <u>2822 Denham Circle</u>			
5. SEX <u>F.</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>10-23-1890</u>	9. AGE (In years last birthday) <u>76</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>			
13. FATHER'S NAME <u>James Harris</u>		14. MOTHER'S MAIDEN NAME <u>Susie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Alvise Nicholson</u> ADDRESS <u>2822 Denham Circle</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Brain abscess</u>		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>arteriosclerotic cardiovascular disease</u> <u>Gangrene of the right foot and lower third of right leg.</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>10-21</u> 19 <u>66</u> to <u>12-6</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>12-6</u> 19 <u>66</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Tsung-jen Huang</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>12-6-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>South Baltimore General Hosp.</u>		23D. ADDRESS <u>Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/8/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>W. Lawrence Cem.</u>	
24D. LOCATION (City, town, or county) <u>Balto.</u>		(State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1966</u>		25B. NAME OF REGISTRAR <u>W. Lawrence</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u> ADDRESS <u>319 N. Howard St.</u>	



66 12213

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12213

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELLWOOD ELEY

2. DATE AND HOUR PRONOUNCED DEAD

12-5-66

10:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION

33 JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2200 E. Biddle Street 21213

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 13-1944

9. AGE (In years  
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY

USA

13. FATHER'S NAME

James H. Eley

14. MOTHER'S MAIDEN NAME

Hattie M. Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Maurice Eley

ADDRESS

Same

18.

E981X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive internal bleeding  
DUE TOGunshot wound of chest involving heart  
and lung

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

In front of 2200 E. Biddle Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) 10:00  
12 5 '66 PM

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-10-66

23C. NAME of CEMETERY or CREMATORY

Carr Center

23D. LOCATION

(City, town, or county)

(State)

Lanham Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

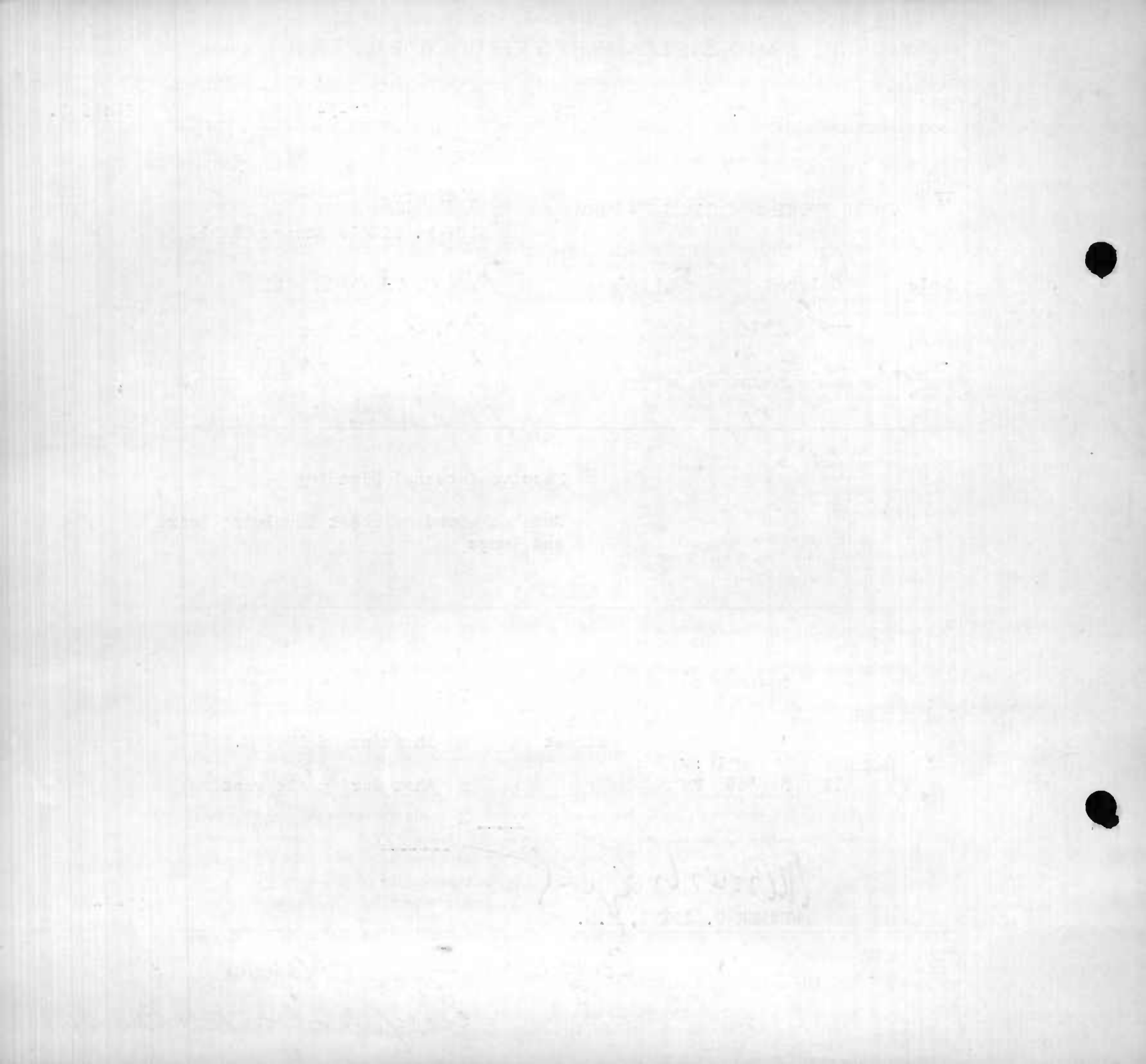
24C. FUNERAL DIRECTOR

ADDRESS

DEC 7 1966

Robert E. Fairley, M.D.

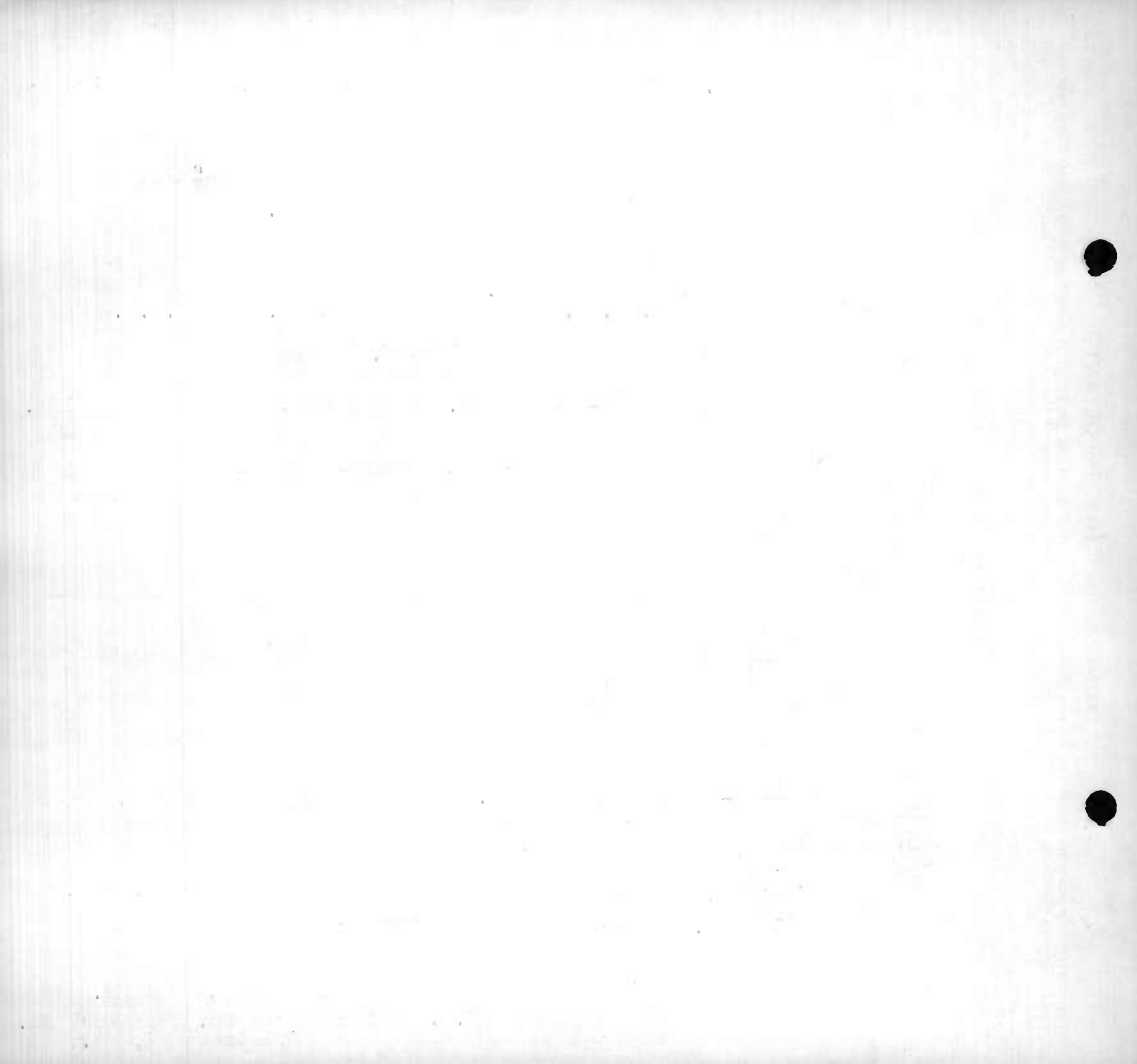
Elmer Wilson 1001 Bramblethorpe



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 12214					Registered No. 66 12214				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Nettie B. Neely					2. DATE AND HOUR OF DEATH December 6, 1966 4:30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House In the Pines, Belvedere					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 5708 Fenwick Ave.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7/5/1882	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk			10B. KIND OF BUSINESS OR INDUSTRY Civil Service Comm.		11. BIRTHPLACE (State or foreign country) Westminster, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamin Buckingham					14. MOTHER'S MAIDEN NAME Eliza J. Ebaugh				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 579-50-4244		17. INFORMANT Mr. Morton Perry, 244 Equitable Bldg.			ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic- Cardio-vascular Disease					INTERVAL BETWEEN ONSET AND DEATH 10 years				
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from January 19 62 to December 6, 19 66, that (I) (we) last saw the deceased alive on December 5, 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Lloyd E. Saylor					23B. DATE SIGNED December 6, 1966				
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor					23D. ADDRESS 3902 York Road				
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12/7/1966		24C. NAME of CEMETERY or CREMATORY Greenmount			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1966			25B. NAME OF REGISTRAR L. E. Saylor			25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.			



H-26

66 12215

BALTIMORE CITY HEALTH DEPARTMENT

66 12215

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH A. HOGARTH

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966 8:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

905 N. Kresson Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Oct. 9, 1894

9. AGE (In years  
lost birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Welder

10B. KIND OF BUSINESS OR INDUSTRY

Welding

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph F. Hogarth

14. MOTHER'S MAIDEN NAME

Catherine M. Knoll Rachel Catherine Noel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-10-20774

17. INFORMANT

Albert Timonium, Md. Albert H. Hogarth, 134 Hollow Brook Rd.

ADDRESS

Lutherville, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/9/1966

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer

23D. LOCATION (City, town, or county)

Baltimore

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 7 1966

24B. NAME OF REGISTRAR

John E. Jenkins

24C. FUNERAL DIRECTOR

H.W. Jenkins &amp; Sons Co. 4905 York Rd.

ADDRESS

Baltimore 12, Md.

V.S. 153

12-14-66

M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <b>66 12216</b>	
BIRTH NO. <b>66 12216</b>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>John H. Kratz</b>			2. DATE AND HOUR OF DEATH <b>Dec. 5, 1966</b> <b>14:54</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>12 E. Lake Ave.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>12 E. Lake Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>4-29-1905</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Frederick Kratz</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>165-03-6428</b>		17. INFORMANT <b>Wilbur Kratz</b> ADDRESS <b>Above</b>
18. <b>4221 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic C.V. Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Arteriosclerotic C.V. Disease</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>		
19A. DATE OF OPERATION <b>5/15</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/15</b> <b>19 58</b> to <b>12/5</b> <b>19 66</b> , that (I) (we) last saw the deceased alive on <b>12/5</b> <b>19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benjamin Highstein</b>			23B. DATE SIGNED <b>12/6/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Benjamin Highstein</b>			23D. ADDRESS <b>121 S. Highland Ave., Balto., Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-8-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION <b>Baltimore</b>		24E. (State) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>	
				ADDRESS <b>4905 York Rd.</b>	

Antenatalsche (Volks)

12/2 21/2 22 12/2

Programm (Hilfs)

1  
5-121

66 12217

BALTIMORE CITY HEALTH DEPARTMENT

66 12217

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOSEPH

SEFCOVIC

2. DATE AND HOUR PRONOUNCED DEAD

December 5, 1966

9:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

6 South Broadway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write "RURAL" and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6 South Broadway Apt. - 5

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

5/21/03

9. AGE (In years last birthday)

63

If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tar Roofer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Schenectady, New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Sefcovic

14. MOTHER'S MAIDEN NAME

Anna Ralbovski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.II

16. SOCIAL SECURITY NO.

212 03 1372

17. INFORMANT

ADDRESS

Mrs. Rose Rubis 143 Mehrhoff Rd.

18.

CAUSE OF DEATH

Little

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/5/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12/7/66

23C. NAME of CEMETERY or CREMATORY

Louisa National Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 7 1966

24B. NAME OF REGISTRAR

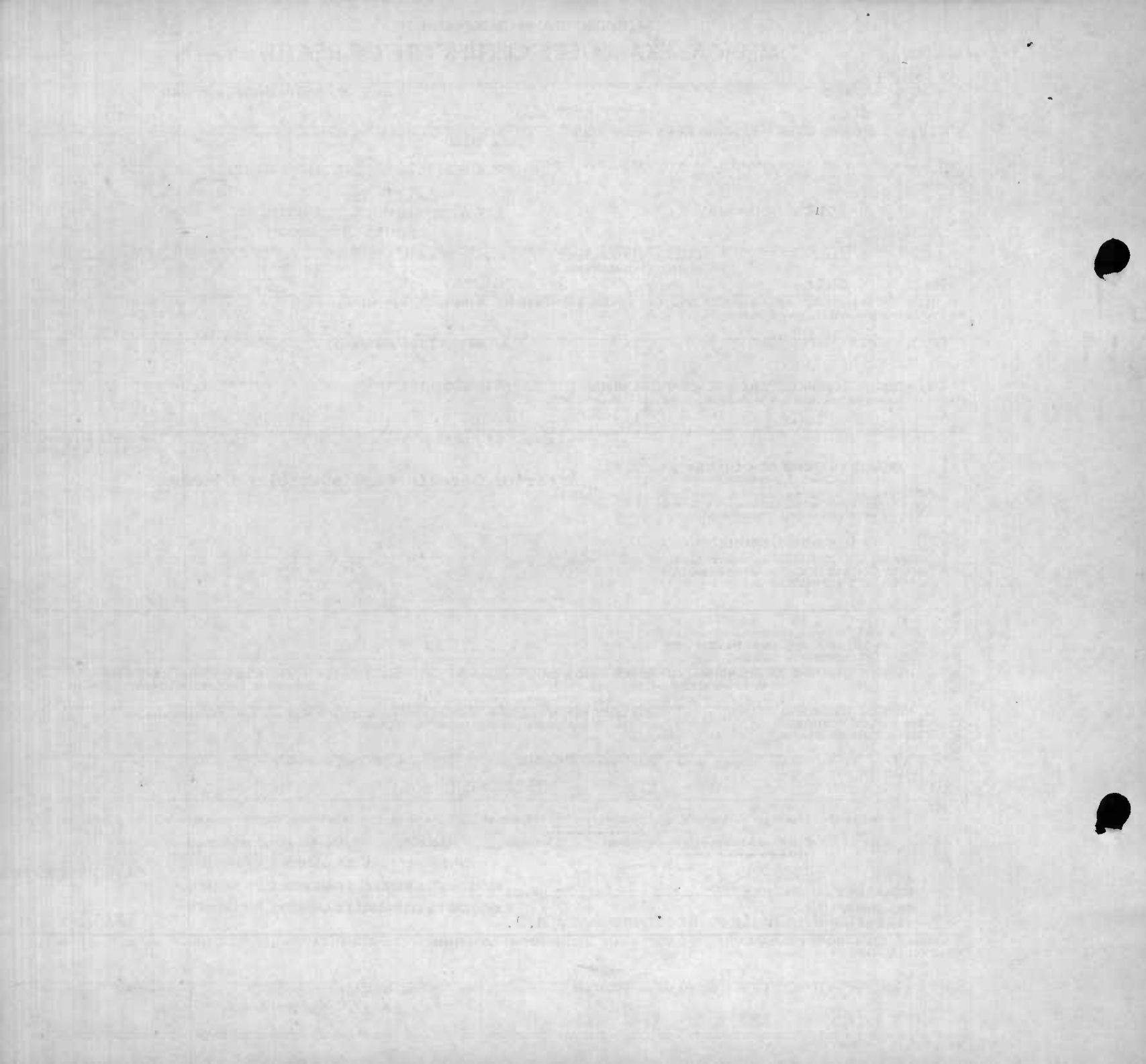
Robert E. Jackson

24C. FUNERAL DIRECTOR

Joseph N. Zannino

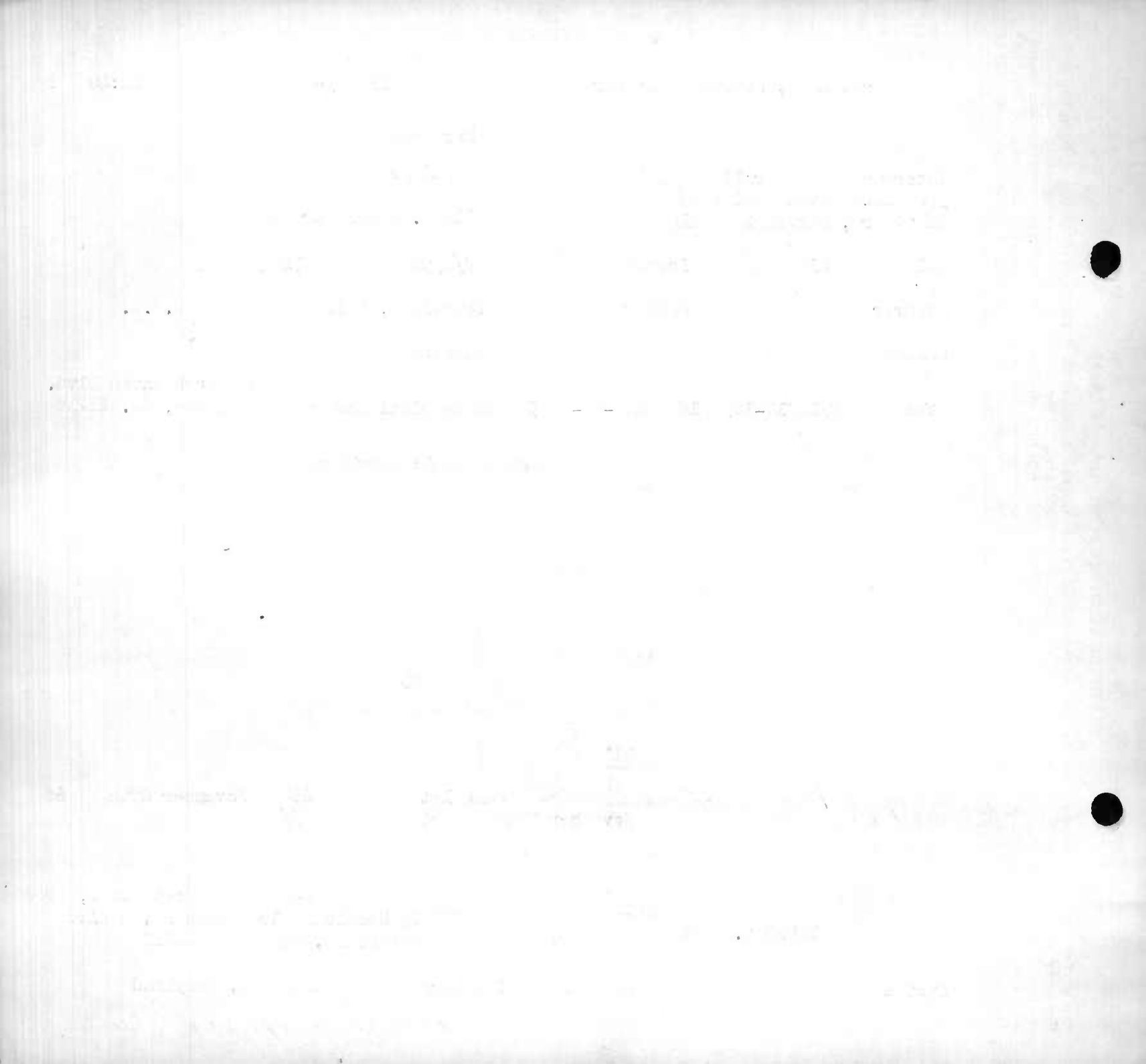
ADDRESS

267 S. Conkling



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12218		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 12218	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>HAGERMAN, Joseph Alexander</b>			2. DATE AND HOUR OF DEATH <b>11/29/66</b>   <b>12:40</b> P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>118 S. Haven Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>8/4/92</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Laurelton, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>7/16/17-12/6/18</b>		16. SOCIAL SECURITY NO. <b>268-12-8885</b>	17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Blvd. Baltimore, Md. 21218</b>		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchogenic Carcinoma</b> (A) DUE TO II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 months</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>7/16/17-12/6/18</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>June 1st</b> 19 <b>66</b> to <b>November 29th</b> 19 <b>66</b> , that (1) (we) lost saw the deceased alive on <b>November 29th</b> 19 <b>66</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.					
23A. SIGNATURE  <b>YOUNG E. CHON</b> M.D.				23B. DATE SIGNED <b>December 1, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHON</b>		23D. ADDRESS <b>VA Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/5/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Loudon National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkman</b>		25C. FUNERAL DIRECTOR <b>Joseph N. Zannone Jr. 263 S. Conkling St</b>	



1  
66-453

66 12219

BALTIMORE CITY HEALTH DEPARTMENT

66 12219

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>ANTOINETTE La LONDE</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>November 30, 1966 9:55 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31 City Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore - 21222</b> D. STREET ADDRESS (If rural, give location) <b>6545 Baltimore Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 28, 1900</b>
9. AGE (In years last birthday) <b>66</b>		10. If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>Napoli</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Mr. Albert LaLonde - 6545 Baltimore Ave</b>		ADDRESS	
18. <b>422,11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (A) _____ (B) _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/1/66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>12/5/66</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
24C. FUNERAL DIRECTOR <b>H. Sander &amp; Sons, Inc., Balto., Md.</b>		ADDRESS	

UNITED STATES DEPARTMENT OF THE INTERIOR

WATER RESOURCES DIVISION

OFFICE

WATER RESOURCES DIVISION  
UNITED STATES DEPARTMENT OF THE INTERIOR

REPORT

WATER RESOURCES DIVISION  
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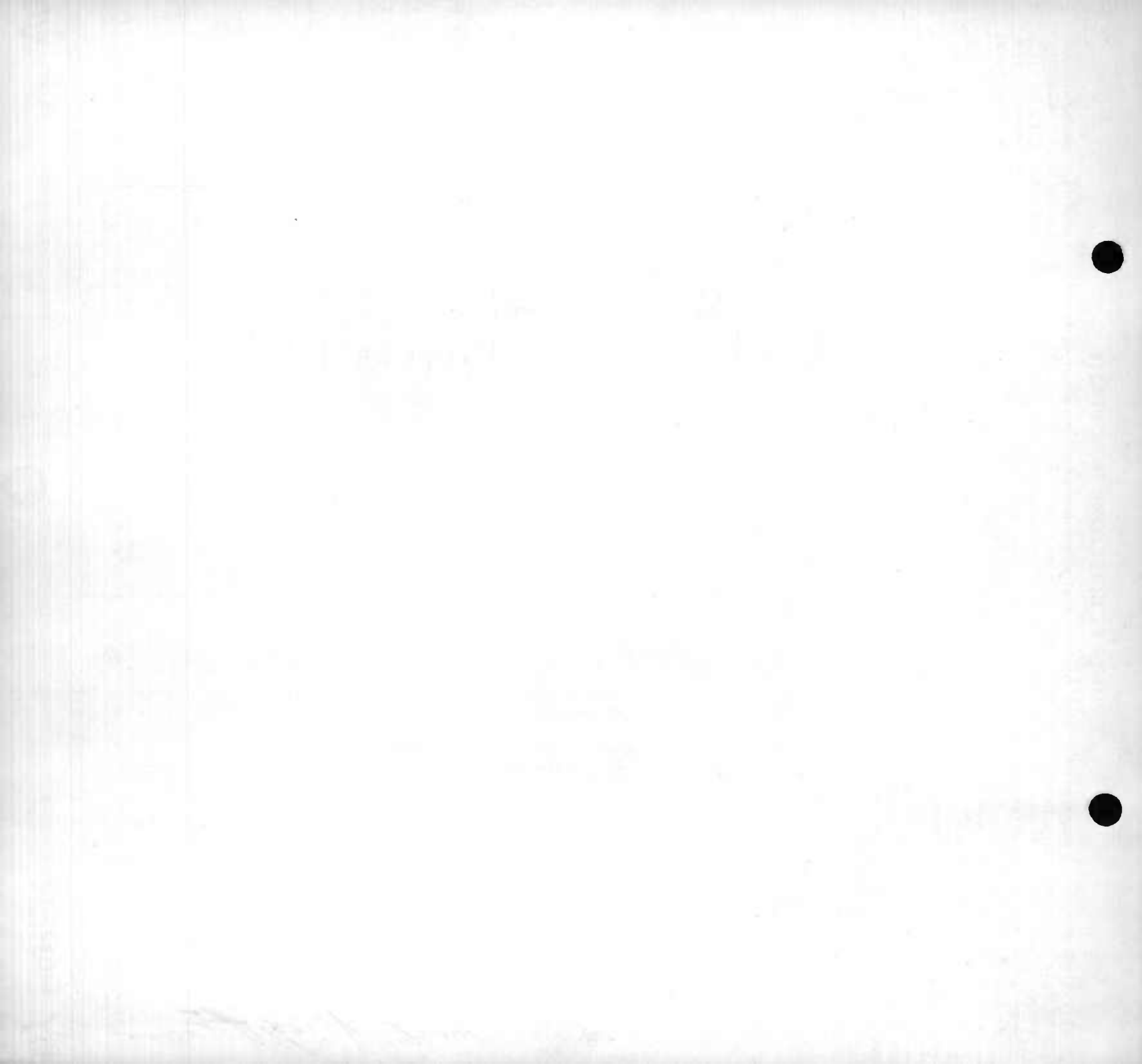
66 12220		BALTIMORE CITY HEALTH DEPARTMENT		66 12220	
BIRTH NO. 63-17042		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
DARRELL DUNGEY		December 5, 1966		4:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
38 University Hospital		Maryland			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
		Baltimore		17-01	
		D. STREET ADDRESS (If rural, give location)			
		900 Argyle Avenue Apt. - 5			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Colored	Child	June 28, 1963	3-1/2	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Child		child		Balto. Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Thomas Otis Williams		Sean Dungey		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no prunknow, If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Mrs. Sean Dungey 185. Bernice Ave.	
18. I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
E919.0		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Close Range Gunshot Wound of Abdomen			
		DUE TO			
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		900 Argyle Avenue Apt. - 5 17-01	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		gun	
12 5 '66 2:59 A				Apparently shot self while playing with	
22.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:			
		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		Rudiger Breitenacker, M.D.		12/5/66	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
BURIAL		12-7-66		Arbutus Mem PK.	
				Arbutus Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
DEC 7 1966		Robert E. Feltman		MORTON + DyeTT 1701 LAURENS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12221</u>	
BIRTH NO. <u>66 12221</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Nicholson, Fred</u>		2. DATE AND HOUR OF DEATH <u>12-5-66 8:30 A. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Dukeland Nursing Home</u> <u>90 1501 Dukeland Street</u> <u>Baltimore Md. #21216</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
5. SEX <u>male</u>		6. RACE <u>negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restless Ironist</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>6/12/97</u>	
13. FATHER'S NAME <u>ABNER Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>MIRINDA Nicholson</u>		9. AGE (In years last birthday) <u>69</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <u>Macon, N.C.</u>	
17. INFORMANT <u>Dukeland Nursing Home</u> <u>1501 Dukeland Street #21216</u>		ADDRESS		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>151 XI</u> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <u>GASTRIC CARCINOMA</u> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) _____			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-31-1966</u> to <u>12-5-1966</u> , that (I) (we) last saw the deceased alive on <u>12-5-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas W. Harris</u>				23B. DATE SIGNED <u>12-5-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Feltman</u>				23D. ADDRESS <u>1501 Dukeland Street #21216</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-8-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Calvary Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>A.A. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Feltman</u>		25C. FUNERAL DIRECTOR <u>Walter H. D. Giff</u>		ADDRESS <u>1501 Dukeland Street #21216</u>	



66 12222

BALTIMORE CITY HEALTH DEPARTMENT

66 12222

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARIO

ORLANDO

2. DATE AND HOUR PRONOUNCED DEAD

December 3, 1966

10:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4766 Shamrock Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Nov. 23 1879

9. AGE (in years  
last birthday)

87

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

Italy U.S.A.

13. FATHER'S NAME

Dominic Orlando

14. MOTHER'S MAIDEN NAME

Maria Ferrera

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

none

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Samuel Orlando 4766 Shamrock Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

13/7-66

23C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery Co. E. North Ave &amp; Rose St.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 7 1966

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Frank D. Heller 322 S. High St.

WALLEY FORD

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>66 12223</u>	
2. BIRTH NO. <u>66 12223</u>		M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>KORYTKOWSKI JULIA B.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH <u>Dec. 5. 1966</u>				M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO Co.</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>22 Elmont Ave.</u>				53-00	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>		8. DATE OF BIRTH <u>4-4-11</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scaler</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AFGDETZ</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony Dobrowski</u>				14. MOTHER'S MAIDEN NAME <u>Stella Skrzek.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-05-1937</u>		17. INFORMANT <u>HELEA ZELECHOWSKI</u>		ADDRESS <u>22 ELMONT AVE (L)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) <u>151X I</u>		CAUSE OF DEATH (A) <u>Carcinomatosis primary stomach</u> (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-11-66</u> to <u>12-5-66</u> , that (I) (we) last saw the deceased alive on <u>12-5-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Nabil F. Warsal</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-5-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>NABIL F. WARSAL</u>				23D. ADDRESS <u>Maryland General Hosp Balto, MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/7/66</u>		24C. NAME of CEMETERY or CREMATORY <u>ST. STANISLAUS CEM</u>		24D. LOCATION (City, town, or county) (State) <u>DUNDALK AVE BALTO MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR ADDRESS <u>DIPPEL BROS INC. 7110 BELAIR RD</u>			





G.W. WARDEN - SR. INVESTIGATOR - MEDICAL EXAMINERS  
RELEASED PER APPROVAL  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12224		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12224	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ANNA B. LANG			2. DATE AND HOUR OF DEATH DEC. 5, 1966 7:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME & HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 6-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 14 IRVINE PL (31)		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/2/88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME UNK KRIPP			14. MOTHER'S MAIDEN NAME UNK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HARRY M LANG 14 IRVINE PLACE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) 493X1 ACUTE MYOCARDIAL INFARCTION OR PULMONARY EMBOLUS CONGESTIVE HEART FAILURE PNEUMONIA		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH MINUTES MINUTES WEEKS WEEK	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19C. DATE OF OPERATION 0 19D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 19E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10/12 1966 to 12/5 1966, that (I) (we) lost saw the deceased alive on 12/5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel J. Tan			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Dec. 5, 1966
23C. PHYSICIAN'S NAME (Type) MANUEL J. TAN			23D. ADDRESS M.D. CHURCH HOME & HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE DEC 8 1966	24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		24D. LOCATION (City, town, or county) (State) NORTH AVE & GAY ST MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS DIPPEL BROS INC 1800 E LOMBARD ST	

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66 12225

BALTIMORE CITY HEALTH DEPARTMENT

66 12225

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CATHERINE

WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

December 1, 1966

7:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00410 Pitman Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

410 Pitman Place

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

11/29/18

9. AGE (In years last birthday)

48

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WASH. D. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Cecilia Ware

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

578 303783

17. INFORMANT

Dolores Brown 2814 Quantico Ave

ADDRESS

18. 3810 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Gastro-intestinal Hemorrhage  
DUE TO

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rupture of Esophageal Varices  
DUE TO

(C) Cirrhosis.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
12/2/66

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

12/8/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION (City, town, or county) (State)

Q. A. County, Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 7 1966

24B. NAME OF REGISTRAR

Robert E. Fickel

24C. FUNERAL DIRECTOR

Joseph J. Lock 1304 N. Central Ave

ADDRESS

Directed  
Wash. D.C.  
4/29/18

Investigative

NO. 100706

RECEIVED

Sup. & Asst. Sup. Bureau  
O.O. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12226		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12226	
I. NAME OF DECEASED (Type or Print) <b>DOUGLAS Foster</b>		2. DATE AND HOUR OF DEATH <b>12-4 1966 12:28 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 George Washington Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>4-01</b> D. STREET ADDRESS (If rural, give location) <b>122 Market PL</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>5-1-1898</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>?</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Ernest Foster</b>			14. MOTHER'S MAIDEN NAME <b>MARY Kelly</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Chart #224 607 Penna AVE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>151X I</b>		CAUSE OF DEATH (A) <b>Carcinoma of stomach</b> DUE TO <b>1st vomited coffee ground material - had pain in epigastrium</b> (B) <b>epigastrium</b> DUE TO (C) <b>arteriosclerotic cardiac vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mths</b> <b>3 yrs</b> <b>3 yrs.</b>	
II <b>Histology of stomach myeloid, stromal ulcer at lig.</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/12 1963</b> to <b>12/4 1966</b> , that (I) (we) last saw the deceased alive on <b>12/4/66</b> and that in (my) (our) opinion death occurred on the date <b>12/4/66</b> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>12:28 P.M.</b>					
23A. SIGNATURE <b>J. N. Mac MURRAY</b>				23B. DATE SIGNED <b>12/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. N. Mac MURRAY</b>				23D. ADDRESS <b>607 Penna Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/8/66</b>		24C. NAME OF CEMETERY <b>Mt Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>	

10-11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12227	
BIRTH NO. 66 12227		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNIE OCTAVIA BROWN		2. DATE AND HOUR OF DEATH 12-2-66 2A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 1006 W. FRANKLIN ST. 00		A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 18-02 D. STREET ADDRESS (If rural, give location) 1006 W. FRANKLIN ST			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec 12, 1895	9. AGE (In years, last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James H. Thompson		14. MOTHER'S MAIDEN NAME MARY Francis Harris			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-36-7392		17. INFORMANT ADDRESS MARY TRUSTY 1006 FRANKLIN	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Coronary Heart disease DUE TO (C) Mild Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5-31-1966 to 12-2-1966, that (I) (we) last saw the deceased alive on 12-2-1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel R. Owings, Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-2-66	
23C. PHYSICIAN'S NAME (Type) SAMUEL R. Owings, Jr.		23D. ADDRESS M.D. 909-11 N. CAREY Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 6, 1966		24C. NAME of CEMETERY or CREMATORY Baltimore National Cem	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1966			
25B. NAME OF REGISTRAR Robert E. Is...		25C. FUNERAL DIRECTOR ADDRESS Joseph S. Rues 2222 N. Hancock Baltimore, Md			



THE UNIVERSITY OF CHICAGO  
LIBRARY  
1000 S. MICHIGAN AVE.  
CHICAGO, ILL. 60607  
TEL. 733-4331

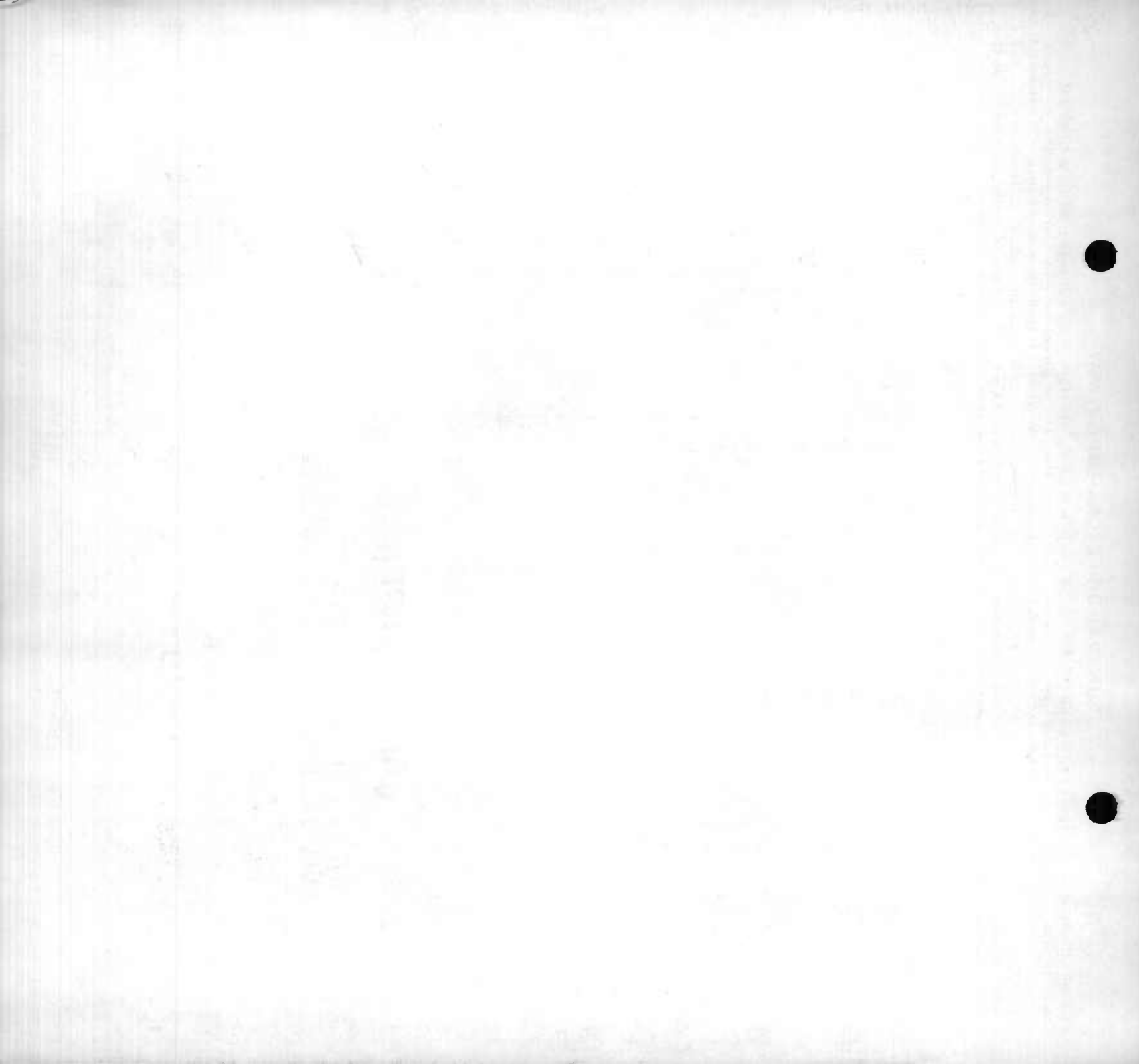
THE UNIVERSITY OF CHICAGO  
LIBRARY  
1000 S. MICHIGAN AVE.  
CHICAGO, ILL. 60607  
TEL. 733-4331



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

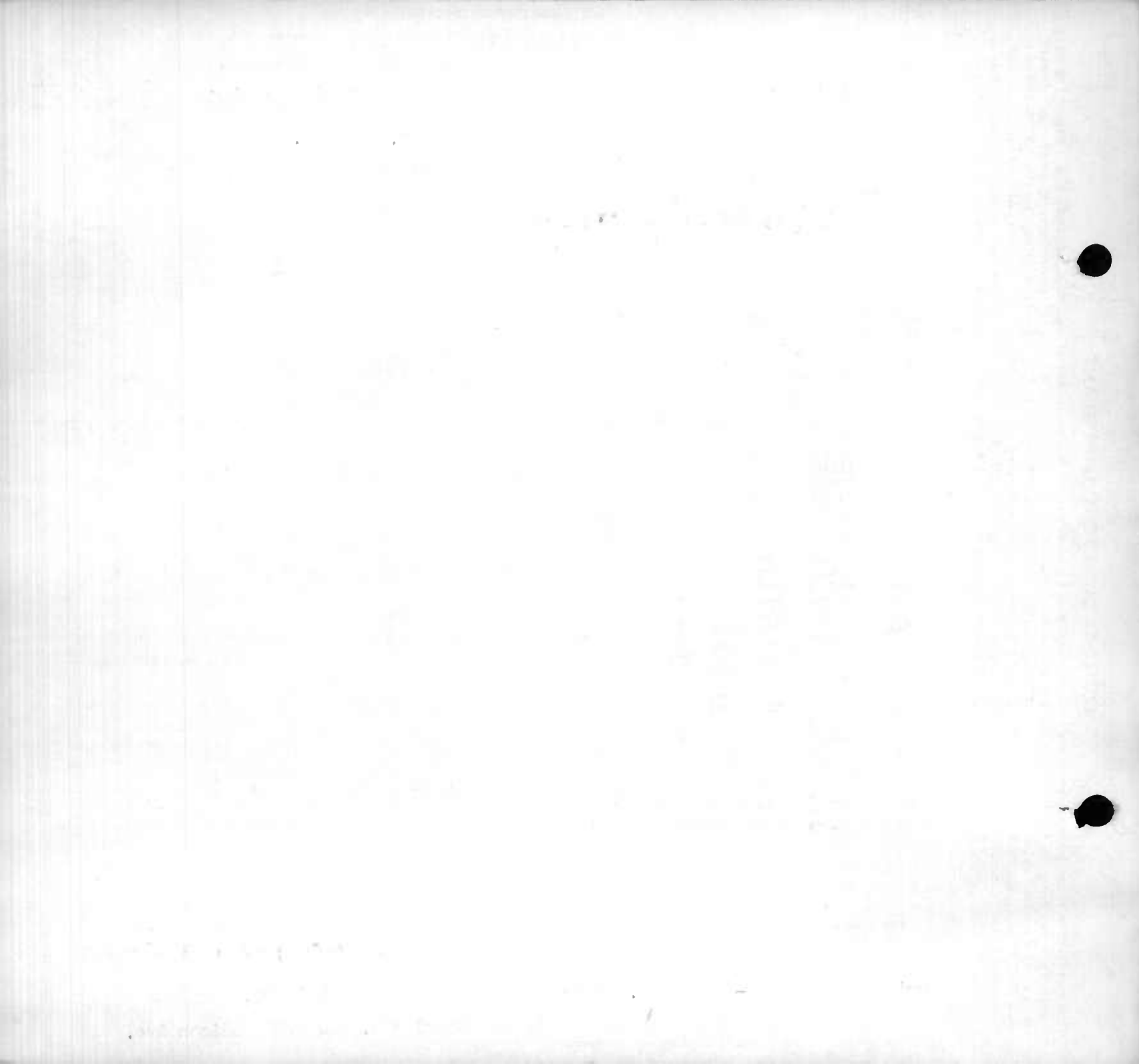
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12228	
BIRTH NO. 66 12228		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) YOUNG, CARRIE E.	
2. DATE AND HOUR OF DEATH 12/3/66 9 <sup>55</sup> P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSP.	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-01		D. STREET ADDRESS (If rural, give location) 428 N. Payson St	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/27/07
9. AGE (In years last birthday) 59		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC MATTHEWS		14. MOTHER'S MAIDEN NAME ELSIE WEEMS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-05-6819	
17. INFORMANT A. HAMILTON YOUNG - 428 PAYSON ST.		ADDRESS	
18. 237X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO BRAIN TUMOR (B) DUE TO (C) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH 34 months		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION 3 12/1/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED B.T.	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/23 1966 to 12/3 1966, that (I) (we) last saw the deceased alive on 12/3 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED 12/3/66	
23C. PHYSICIAN'S NAME (Type) ARNOLDO SCHUPAK M.D.		23D. ADDRESS UNIVERSITY HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/8/66	
24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR CHARLES R. LAW - 802 MADISON AVE.		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12229		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12229	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BLANCHE BARNES</b>		2. DATE AND HOUR OF DEATH <b>12/2/66 12:46 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		808 St. Paul St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
38 <del>W</del> <b>W</b> <b>UNIVERSITY Hosp.</b>		Baltimore		11-00	
D. STREET ADDRESS (If rural, give location)		Maryland			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>11/5/94</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
13. FATHER'S NAME <b>George Johns -</b>		14. MOTHER'S MAIDEN NAME <b>Mary -</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Chas.</b> ADDRESS	
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <b>Arteriosclerotic heart disease -</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Diabetes Mellitus</b>		<b>8 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Coronary Stenosis</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>11/29</b> 19 <b>66</b> to <b>12/2</b> 19 <b>66</b> that (1) (we) last saw the deceased alive on <b>12/1</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
23A. SIGNATURE <b>E Ann Robinson</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/2/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>E Ann ROBINSON</b>		23D. ADDRESS <b>U H - Lombard &amp; Green Sts</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-7-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. ADDRESS (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Falkland</b>		25C. FUNERAL DIRECTOR <b>Charles R. Law</b> ADDRESS <b>802 Madison Ave.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>524 66 12230</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12230</b>	
M.E. CASE NO.		Catherine G. Hensel		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Catherine Hensel</i>		2. DATE AND HOUR OF DEATH <i>Dec 5 / 66 9:00 AM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 B.C.H.</i> <b>4940 Eastern Avenue, Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 15-05</b> D. STREET ADDRESS (If rural, give location) <b>3301 Park Circle 21215</b>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>11/11/08</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Hensel</b>		14. MOTHER'S MAIDEN NAME <b>Margaret <del>XXXX</del> Grob</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-5074</b>		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>	
18. <i>35611</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Myotrophic Lateral Sclerosis</i> DUE TO <i>AND Dementia.</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>10-5-</b> <b>19 66</b> to <b>12-5-</b> <b>19 66</b> , that (I) (we) last saw the deceased alive on <b>12-5-</b> <b>19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Fred J. Kader</i> M.D.		23B. DATE SIGNED <i>Dec 5 / 66</i>		23C. PHYSICIAN'S NAME (Type) <b>F. J. KADER</b>	
23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/9/66</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1966</b>	
25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>B. Vernon ...</i>		25D. ADDRESS <b>4611 Park Heights Ave.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

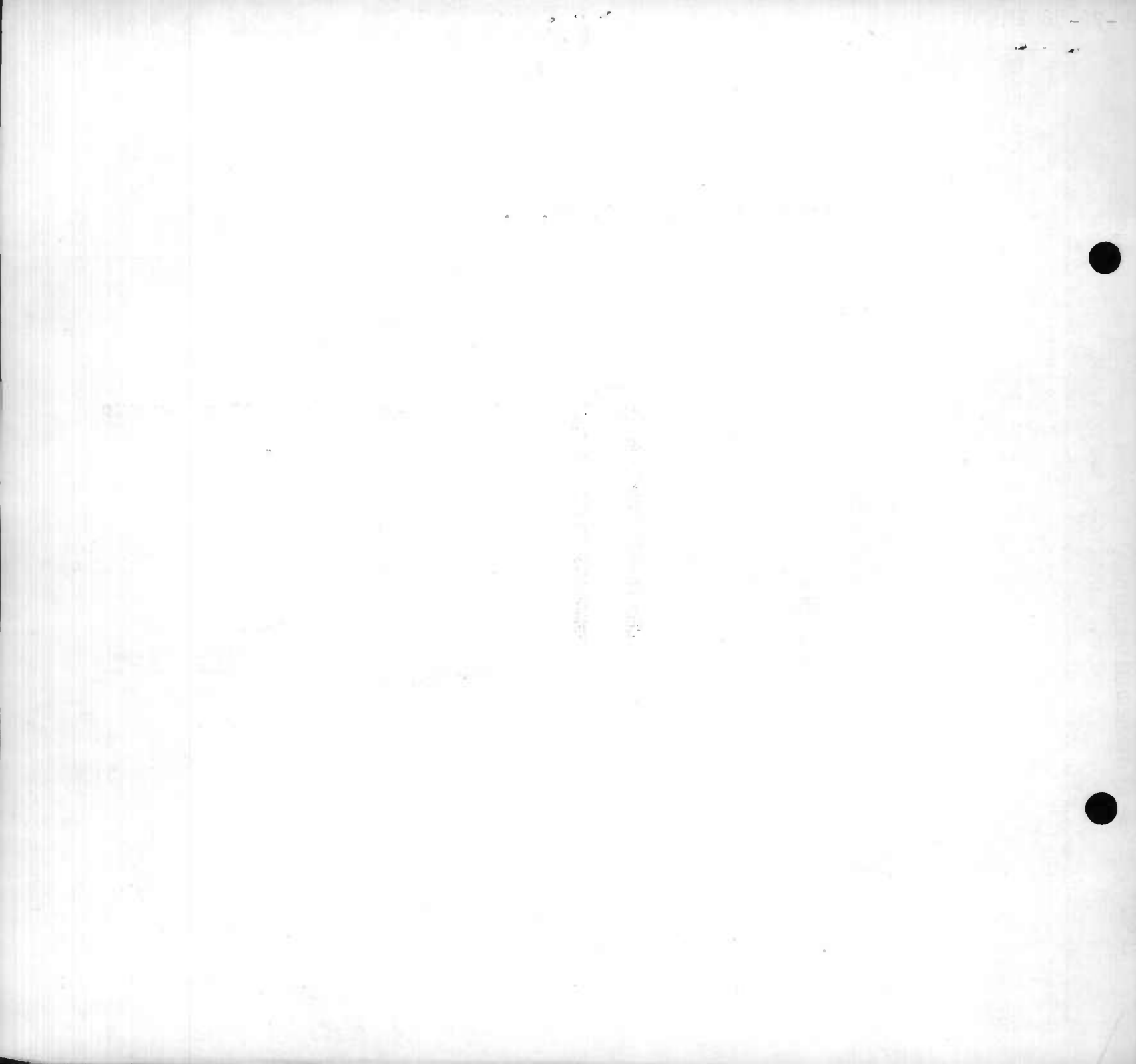
BIRTH NO. 66 12231		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12231	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>PHILLIPS, MRS. LILLIAN</i>			2. DATE AND HOUR OF DEATH <i>12-6-66 11:30 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>X</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>35 Church Home &amp; Hospital 100 N. Broadway Baltimore</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 5-01</i>		
D. STREET ADDRESS (If rural, give location) <i>300 Spring Ct</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>4-15-08</i>	9. AGE (In years last birthday) <i>58</i>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>POLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>AMERICAN</i>
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT ADDRESS <i>LEO PHILLIPS (Husb) 300 Spring Ct</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>331X I</i>			CAUSE OF DEATH <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12-7 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		(B) DUE TO
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-4-66</i> to <i>12-6-66</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12-6-66</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>12-6-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. A. E. SIBONG, JR.</i>				23D. ADDRESS <i>Church Home &amp; Hospital</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12-9-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>HOLY ROSARY CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 7 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, JR.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>JOHN M. WEBER &amp; SONS INC 4015 E. CHESTER ST.</i>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12232		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12232 ✓	
M.E. CASE NO. 65 23425		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Elizabeth Patcher			2. DATE AND HOUR OF DEATH 11/25/66 1650 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balt. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-38 D. STREET ADDRESS (If rural, give location) 3411 W. Forest Park Ave		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S.	8. DATE OF BIRTH 9/21/65	9. AGE (In years last birthday) 1 yr -	10. Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Foster mother		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Phoebe Whitehead ADDRESS RECORDS-BCH-4940 Eastern Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.) E 917.01 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) sepsis (B) pneumonia (C) 35 % 2nd degree burns INTERVAL BETWEEN ONSET AND DEATH ~ 12 hrs ~ 12 hrs 23 days		
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 15-38		
21D. TIME OF INJURY (APPROX.) 11 2 66 ~5 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? foster sib bathing child; scalding injury		
22. I certify that (I) (this hospital) attended the deceased from 11/2 19 66 to 11/25 19 66, that (I) (we) last saw the deceased alive on 11/25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ann Louise S Silver M.D.			23B. DATE SIGNED 11/25/66		
23C. PHYSICIAN'S NAME (Type) Dr. Ann Silver			23D. ADDRESS Baltimore City Hospitals		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 12-3-66	24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224		
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1966		25B. NAME OF REGISTRAR Robert E. Farber	25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12233		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12233	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) OLIVE RHOTEN		2. DATE AND HOUR OF DEATH 12/4/66 6:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 1		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-09	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md GEN HOSPITAL BALTO, MD		D. STREET ADDRESS (If rural, give location) 1513 NORTHBOURNE Rd			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-15-96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME R. EDWIN ARMACOST		14. MOTHER'S MAIDEN NAME BERTHA C. Fowble	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-46-9854		17. INFORMANT Kenneth R Koskenen MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH (A) DUE TO Myocardial Infarction (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 12/29 1966 to 12/4 1966, that (1) (we) last saw the deceased alive on 12/4 1966 and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth R Koskenen MD		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/4/66	
23C. PHYSICIAN'S NAME (Type) Kenneth R Koskenen MD		23D. ADDRESS Md GEN HOSP BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/66		24C. NAME of CEMETERY or CREMATORY Grace Methodist Cemetery	
24D. LOCATION (City, town, or county) Balto. Co.				24E. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1966		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Tipton-Eline Fun. Home	
				ADDRESS Hampstead, Md.	

1010 WESTINGHOUSE

11-12-10

MARKED

F W

MR

NAME

RENTAL

R EDWIN ARNOLD

11-12-10

NO

12/10

12/10

12/10

12/10

12/10

12/10

12/10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12234		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12234	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FAULCONER, RAYMOND		2. DATE AND HOUR OF DEATH 2 PM - 12-4-66 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL 38 BALTIMORE 1, MD.		A. STATE MD. B. COUNTY Balto. Co.			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Helper Building		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2-24-37	
13. FATHER'S NAME THOMAS FAULCONER		14. MOTHER'S MAIDEN NAME AGNES PERRYMAN		9. AGE (In years lost birthday) 29	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-34-0050		17. INFORMANT Agnes Faulconer, Beltsville, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SUBACUTE GLOMERULONEPHRITIS		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CAUSING IT.					
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-30-1966 to 12-4-1966, that (I) (we) last saw the deceased alive on 12-4-66, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stuart L. Fine		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-4-66	
23C. PHYSICIAN'S NAME (Type) STUART L. FINE		23D. ADDRESS University Hospital Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 7, 1966		24C. NAME of CEMETERY or CREMATORY Zoar Church Cemetery	
24D. LOCATION Locust Grove, Va.		24E. CITY, town, or county Arlington, Va.		24F. STATE Va.	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Agasch's Sons - Hyattsville, Md.	

Carver-Holmes Building  
Washington, D.C.

Office of the Surgeon General  
Department of Health, Education & Welfare

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ANN ARBOR, MI 48106

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Ann Arbor, MI 48106

D-530

66 12235

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12235

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DAISY Belle

DEMUTH

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966

3:08 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

914 Ashburton Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

914 Ashburton Street 21216

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

3/28/1898

9. AGE (In years  
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John

A.?

Smith

14. MOTHER'S MAIDEN NAME

Alice

M.

Stemmell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

214-22-6673

17. INFORMANT

ADDRESS

Mr. John W. DeMuth 57 Ritters Lane 21117

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

23C. NAME of CEMETERY or CREMATORY

Pleasant Hill Cemetery

23D. LOCATION

(City, town, or county)

Owings Mills, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 7 1966





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12236	
66 12236 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Cecilia Meyer</i>				12/4/66 6:40 pm M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>			A. STATE B. COUNTY MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			O. STREET ADDRESS (If rural, give location) 1809 FOREST PARK AVE.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-28-94	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME JOSEPH M. MOYLAN			14. MOTHER'S MAIDEN NAME JOHANNA O'KEEFE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 106-01-3377 D		17. INFORMANT ADDRESS Mrs. William Horne 2 Gwynn Lake Drive	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Respiratory Arrest (B) Aspiration (C) Chronic lung Disease		
INTERVAL BETWEEN ONSET AND DEATH Several Min.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Post op Ventral Hernia Repair		
19A. DATE OF OPERATION 11/30/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ventral Hernia		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/1 1966 to 12/4 1966, that (I) (we) last saw the deceased alive on 12/4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. F. Brooker Jr.</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/4/66
23C. PHYSICIAN'S NAME (Type) Andrew F. Brooker Jr.			23D. ADDRESS J. H. H.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/7/1966	24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1966		25B. NAME OF REGISTRAR R. B. E. Tolson		25C. FUNERAL DIRECTOR ADDRESS Wm. J. Fikner & Sons Baltimore, Md.	

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Handwritten text at the bottom of the page, including what appears to be a date and possibly a location or address.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12237	
BIRTH NO. 66 12237		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JONES, LEOLA MAY		2. DATE AND HOUR OF DEATH 12-5-66 9:00A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 27-18 4909 Litchfield Ave. 21215			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10-1-88	9. AGE (In years lost birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PETER Lainhart		14. MOTHER'S MAIDEN NAME IDA REED		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE No	
16. SOCIAL SECURITY NO. 212-12-1617D		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO A.S.C.V.D. (B) DUE TO C.V.A. (C) Coronary Disease		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 15 19 66 to DECEMBER 5 19 66, that (I) (we) last saw the deceased alive on DECEMBER 5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ewaldo Weiss		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-5-66	
23C. PHYSICIAN'S NAME (Type) EWALDO WEISS		23D. ADDRESS M.D. ST. AGNES HOSPITAL - CATONE & WILKENS 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/8/1966	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Wm. J. Jackson Baltimore, Md. North Pa.	

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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B 346

66 12238		BALTIMORE CITY HEALTH DEPARTMENT		66 12238	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		JOHN J. BUTLER		2. DATE AND HOUR PRONOUNCED DEAD 12-2-66 7:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		B. COUNTY 6-05	
402 Maderia St.		D. STREET ADDRESS (If rural, give location)		Baltimore 402 Maderia St.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept, 29/1919	9. AGE (In years last birthday) 47	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Butler		14. MOTHER'S MAIDEN NAME Anna--	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. WW2 212-20-4975		17. INFORMANT Mrs. Lily F. Butler 402 N. Maderia St. 31	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO Cor pulmonale Pulmonary tuberculosis (advanced, active) (B) DUE TO (C).....		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Dec. 7/66		23C. NAME of CEMETERY or CREMATORY Balto. National Cem.	
24A. DATE REC'D BY HEALTH DEPT. DEC 7 1966		24B. NAME OF REGISTRAR Paul E. Farkner		24C. FUNERAL DIRECTOR Philip H. Hewigson	
23D. LOCATION (City, town, or county) Balto. Md.		23E. ADDRESS 2024 Orleans St. 31			

WALL LIEY MOBILE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 12239		M-300		66 12239	
M.E. CASE NO.		CERTIFICATE OF DEATH		6.30 A.M.	
1. NAME OF DECEASED (Type or Print)		MATHIO, VINCENT J.		2. DATE AND HOUR OF DEATH 12-7-66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
34 BON SECOURS HOSP.		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE		1903	
		D. STREET ADDRESS (If rural, give location)			
		907 HOLLINS ST. (21223)			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/4/20	9. AGE (In years last birthday) 46	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Chauffeur		Transfer Co.		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
DANIEL MATHIO		ROSE PAGE		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				Dr. Eva Mathio - 907 Hollins St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
18. I		Emaciation		7.6 mo.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Carinomatosis			
		(C) Ca. of stomach			
II		Broncho pneumonia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10-7-66 19 to 12-7 1966, that (we) last saw the deceased alive on 12-7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose A. Palancar				23B. DATE SIGNED 12/7/66	
23C. PHYSICIAN'S NAME (Type) JOSE A. PALANCAR				23D. ADDRESS BON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/10/66		Holy Redeemer Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 8 1966		John E. Feltner		John J. Gorman & Son Inc.	
				Address 907 Hollins St. 23rd.	

10/7/62

BEN SECURE HOSPITAL

TEAR A. PATANCA  
8/10/62

12-7

10-7-62

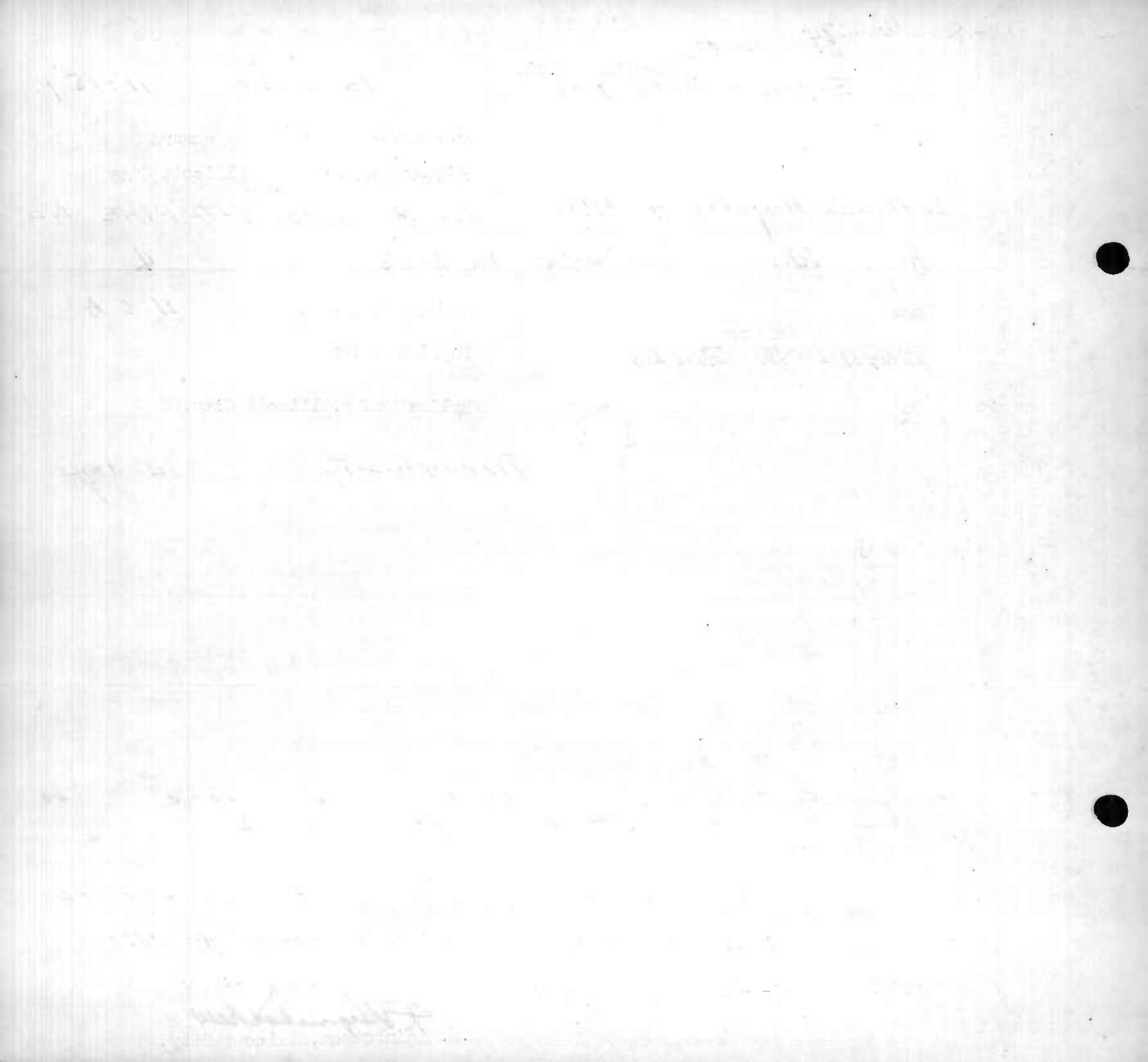
12-7



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

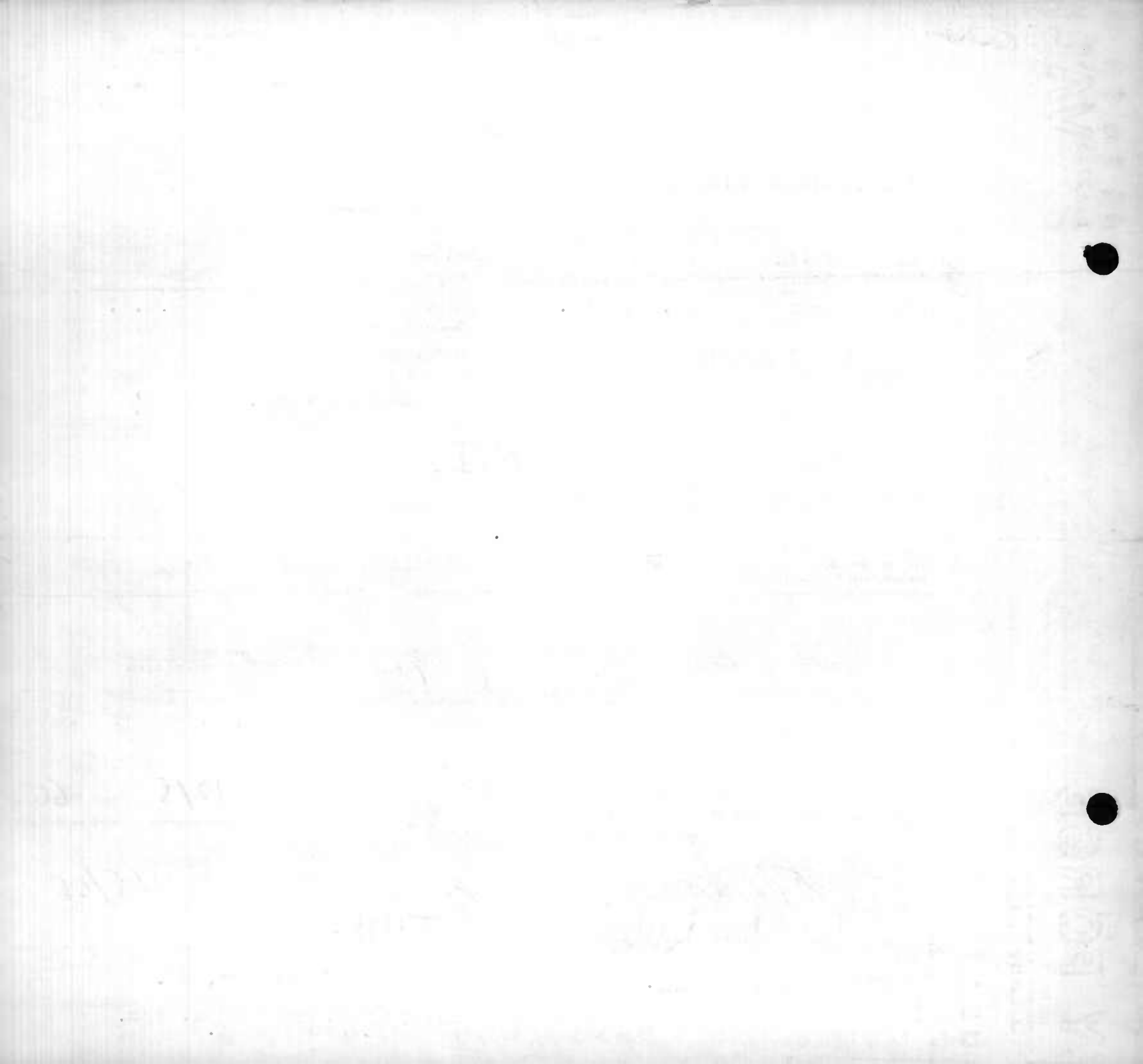
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. <u>66-26084</u> <u>12240</u>					CERTIFICATE OF DEATH					Registered No. <u>66-12240-4</u>									
M.E. CASE NO. <u>66-12240</u>																			
1. NAME OF DECEASED (Type or Print) <u>Zacks, Baby</u>										Loretta Marie					2. DATE AND HOUR OF DEATH <u>12-6-66</u> <u>11:15 P.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard Co.</u>									
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital of MD.</u>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Ellicott City</u> <u>63-00</u>									
D. STREET ADDRESS (If rural, give location) <u>310 A. BALTO. NATL PIKE NB</u>																			
5. SEX <u>F.</u>		6. RACE <u>W.</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>		8. DATE OF BIRTH <u>12-3-66</u>		9. AGE (In years last birthday) <u>4</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Unknown</u>										14. MOTHER'S MAIDEN NAME <u>Phyliss Zacks</u>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Phyliss Zacks, Ellicott City, Md</u>									
18. <u>77681</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> <u>1966</u> to <u>12-6</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>12-2</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <u>Woon Ja Kim</u> M.D.										23B. DATE SIGNED <u>12-6-66</u>									
23C. PHYSICIAN'S NAME (Type) <u>WOON JA KIM</u> M.D.										23D. ADDRESS <u>Lutheran Hosp. of MD</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>12-7-1966</u>					24C. NAME of CEMETERY or CREMATORY <u>Good Shepherd</u>					24D. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1966</u>					25B. NAME OF REGISTRAR <u>R. E. Fairman</u>					25C. FUNERAL DIRECTOR <u>F. C. Higginbotham</u>					ADDRESS <u>Ellicott City, Md</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 12241					66 12241				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>ALBERT ASKWITH</b>					2. DATE AND HOUR OF DEATH <b>12-5-66 4.00 A M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>					A. STATE <b>MARYLAND</b>				
(If not in hospital or institution, give street address or location)					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				
					D. STREET ADDRESS (If rural, give location) <b>2226 HENNEMAN STREET</b>				
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>MARRIED</b>		8. DATE OF BIRTH <b>2-19-01</b>		9. AGE (in years lost birthday) <b>65</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lithographer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Amer. Can Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>ALBERT ASKWITH</b>					14. MOTHER'S MAIDEN NAME <b>unknown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Ruth Askwith, wife, above</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>M.I.</b>					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>12/5 1966</b> to <b>12/5 1966</b> , that (I) (we) last saw the deceased alive on <b>12/5 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>W Stan Wilson</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/5/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>W Stan Wilson</b>					23D. ADDRESS <b>JHH.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/8/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Olive Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>2601 E. Madison St.</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12242</b>	
BIRTH NO. <b>66 12242</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Mamie Elizabeth Johnson</b>		2. DATE AND HOUR OF DEATH <b>December 4, 1966 1300 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>17-03</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore City</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>725 George Street apt 3A</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>never married</b>	8. DATE OF BIRTH <b>1/13/88</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Annapolis Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>not known Horace</b>		14. MOTHER'S MAIDEN NAME <b>not known Mary</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>not known</b>		17. INFORMANT <b>Mr Eugene White 3019 Ridge 200d Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>171X I</b>		CAUSE OF DEATH (A) <b>Uremia</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>ureteral obstruction</b> DUE TO		<b>unknown</b>	
(C) <b>carcinoma of cervix treated by irradiation</b>				<b>20 yr.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>11/15/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>diagnostic cystoscopy</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/14/66</b> 19 to <b>December 4</b> 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 4</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David A. Shafritz</b> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>David A. Shafritz</b> M.D.		23D. ADDRESS <b>Univ Hosp. Balt. Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem Park</b>	
24D. LOCATION <b>Baltimore Md</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>	

Annals 18

Annals

1871

1871

Mr. James White 1871

1871

1871

1871

1871

1871

48-23-25  
NIW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12243		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12243	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margaret Schubert		2. DATE AND HOUR OF DEATH 5 Dec 1966 10 <sup>05</sup> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-10 D. STREET ADDRESS (If rural, give location) 416 N. HIGHLAND AVENUE - 21224			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1/23/92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) MARYLAND, Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHRISTIAN JERSCHIED		14. MOTHER'S MAIDEN NAME JULIA LAMPLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-24-4789		17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cardiac Arrhythmia (B) DUE TO Circulatory Collapse (C) DUE TO Aspiration Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 40 hrs +? 40 hrs +? 54 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Padgett's Disease		16 yrs	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19A. AUTOPSY (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from 3 Dec 1966 to 5 Dec 1966, that (I) <del>(we)</del> last saw the deceased alive on 5 Dec 1966 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE Dudley A. Raine, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5 Dec 1966	
23C. PHYSICIAN'S NAME (Type) DUDLEY A. RAINE, JR.		23D. ADDRESS BALTIMORE CITY HOSPITALS M.D. 4940 Eastern Avenue, Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/8/66		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	
25D. ADDRESS					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print)		TROST, Laura A. (Daisy)		2. DATE AND HOUR OF DEATH 3 December 1966 8 <sup>00</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 31		(If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE MARYLAND B. COUNTY BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00	
				D. STREET ADDRESS (If rural, give location) 410 DELAWARE AVENUE - 21221	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 12/2/82	9. AGE (In years lost birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) MARYLAND Baltimore	
13. FATHER'S NAME William H. Henze				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-5499B		17. INFORMANT RECORDS: BCH, 4940 Eastern Ave, Balto. Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 154 X 14 260 X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. diabetes mellitus				CAUSE OF DEATH (A) Gram negative septicemia DUE TO (B) Urinary obal retention DUE TO (C) carcinoma of rectum? INTERVAL BETWEEN ONSET AND DEATH 24 hrs 30 hrs 4 years	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cancer		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 11-29 1966 to 12-3 1966 that (we) last saw the deceased alive on 12-3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel C. Hadlock M.D.				23B. DATE SIGNED 4 Dec 1966	
23C. PHYSICIAN'S NAME (Type) DANIEL C. HADLOCK M.D.				23D. ADDRESS BCH, 4940 Eastern Ave. Balto. Md. 21224 1620 McELDERY ST., BALT., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/66		24C. NAME of CEMETERY or CREMATORY Lorraine Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1966		25B. NAME OF REGISTRAR D. E. F. Adams		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	



F-623

## BALTIMORE CITY HEALTH DEPARTMENT

66 12245

BIRTH NO. 66 12245 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)Hattie  
ANNETTE H. FORREST

2. DATE AND HOUR PRONOUNCED DEAD

December 3, 1966 4:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

003304 Elmley Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3304 Elmley Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
divorced

8. DATE OF BIRTH

10/2/1902

9. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James Eleder

14. MOTHER'S MAIDEN NAME

Marie (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, fam, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)Charles S. Springate  
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/7/66

23C. NAME of CEMETERY or CREMATORY

Druid Ridge Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 8 1966

24B. NAME OF REGISTRAR

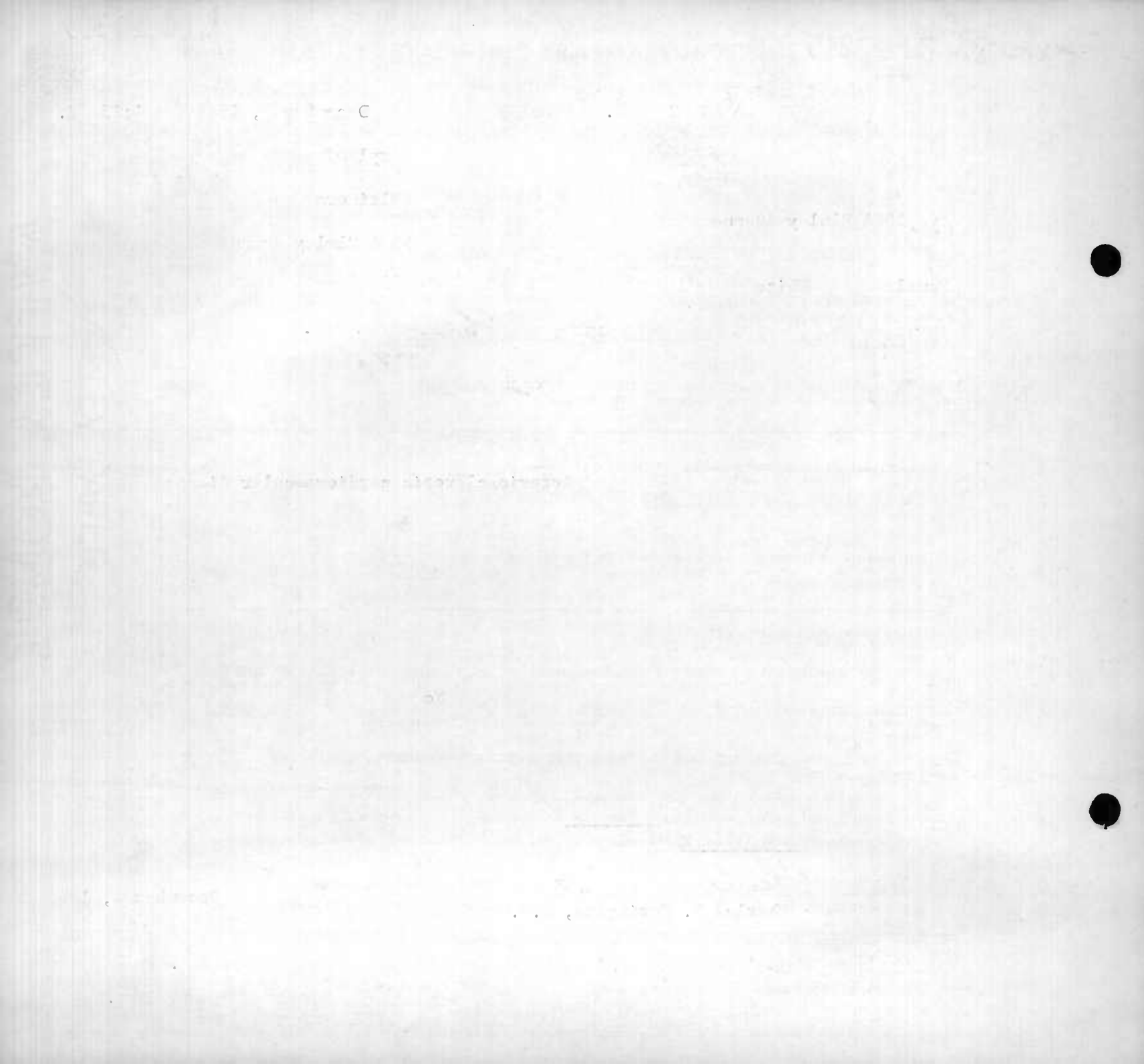
Robert E. Farkas

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane



48-19-66

ED

5760 66 12246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 12246

1. NAME OF DECEASED

(Type or Print)

HARRY B. KNORR

2. DATE AND HOUR OF DEATH

2 DECEMBER 1966 2<sup>30</sup> P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

21220 005

53-00

D. STREET ADDRESS (If rural, give location)

Box 40 Clarkspoint Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

10-17-92

9. AGE (In years lost birthday)

74

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Aerco Co.

11. BIRTHPLACE (State or foreign country)

Maryland Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Knorr

14. MOTHER'S MAIDEN NAME

Catherine Roeder

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

220-01-0239-1

16. SOCIAL SECURITY NO.

220-01-0239-1

17. INFORMANT

BCH: Records 4940 Eastern Ave. Baltimore, Md.

ADDRESS #21224

18. 331X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

(L) CVA

THROMBOSIS OF RIGHT MIDDLE CEREBRAL ARTERY

(B) DUE TO

? Aspiration pneumonia

(C)

INTERVAL BETWEEN ONSET AND DEATH

7 days

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

NO

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 26 NOVEMBER 2, 1966 to 2 DECEMBER 1966, that (I) (we) last saw the deceased alive on 2 DECEMBER, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Daniel D. Foote

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

2 DECEMBER, 1966

23C. PHYSICIAN'S NAME (Type)

Daniel D. Foote

M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Maryland #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/6/66

24C. NAME of CEMETERY or CREMATORY

Moreland Mem. Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1966

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc

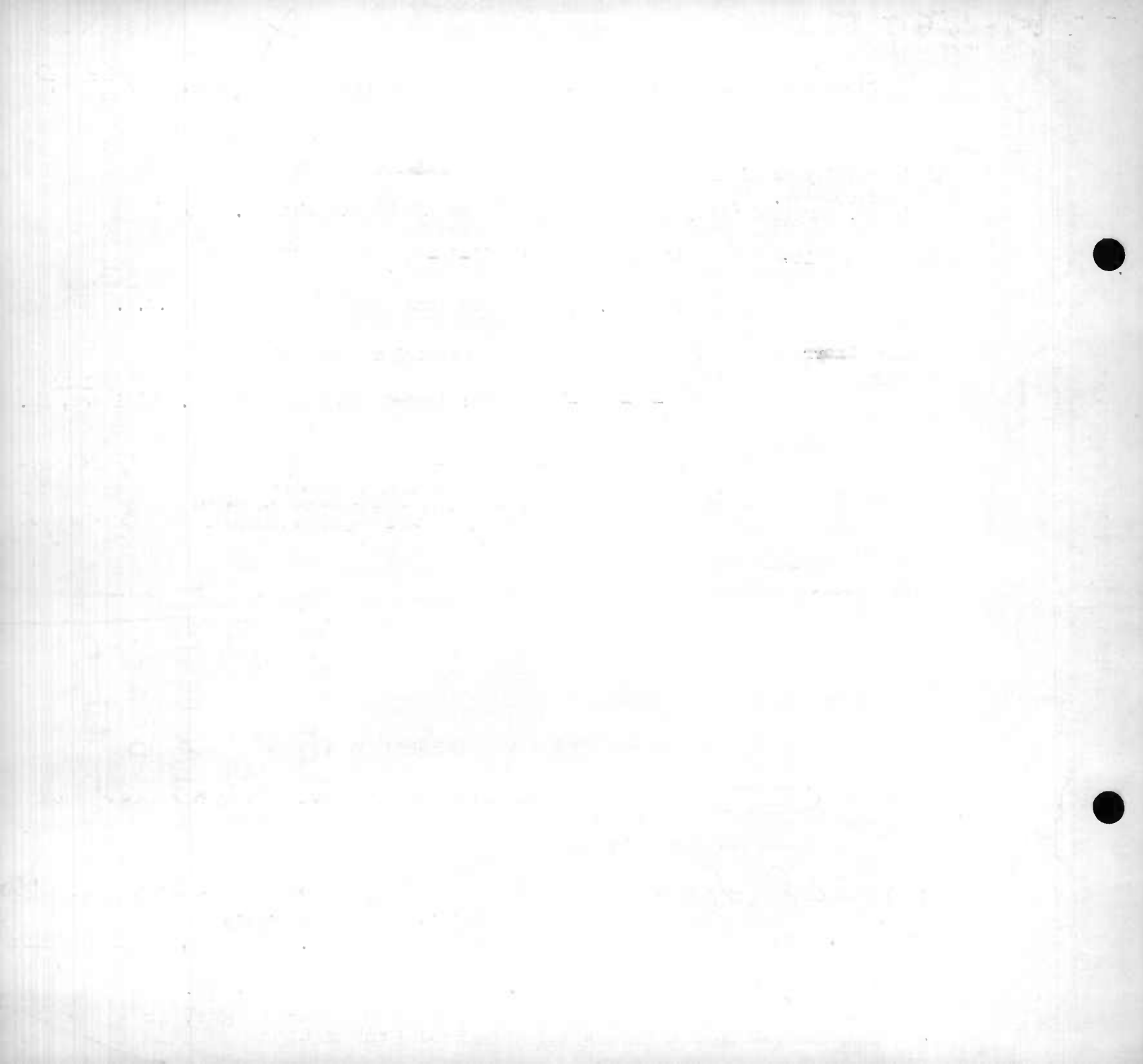
3321 Grebbs Lane

ADDRESS

150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.2em;">66 12247</span>	
BIRTH NO. <span style="font-size: 1.2em;">66 12247</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">SCHMITT, Mr. JOHN</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12-5-66</span>   <span style="font-size: 1.2em;">1:30 A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">3510 N. Broadway Baltimore, Md.</span>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE 6-01</span>			
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">432 N. LINWOOD AVE.</span>			
5. SEX <span style="font-size: 1.2em;">male</span>	6. RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7-30-89</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">77</span>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Salesman</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Salesman</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">H.B. Davis &amp; Co.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">American</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">MICHAEL SCHMITT</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARGARET SCHAFER</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">yes</span> <span style="font-size: 1.2em;">Army WW 1</span>				16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-01-0676</span>		17. INFORMANT <span style="font-size: 1.2em;">CATHERINE SCHMITT (W)</span>	
18. <span style="font-size: 1.2em;">457X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Myocardial Abnl. heart, 14-15,</span> DUE TO (B) <span style="font-size: 1.2em;">atherosclerosis, heart</span> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">hours</span> <span style="font-size: 1.2em;">unknown</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">Coronary Sclerosis &amp; Acl Myocardial Heart</span>							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <span style="font-size: 1.2em;">Yes</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Dec. 4</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">Dec 5</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Dec 5</span> 19 <span style="font-size: 1.2em;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Rodelio M. Lira</span>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">12-5-66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Rodelio M. Lira</span>				23D. ADDRESS <span style="font-size: 1.2em;">Church Lane &amp; Hosp.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12/9/66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 8 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fairbank</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Schimunek Funeral Home, Inc.</span>		ADDRESS <span style="font-size: 1.2em;">23331 Brehms Lane</span>	

RECEIVED FROM THE  
BIRMINGHAM, ALA.

WILHELM SCHMITT

1-30-89 77

STONYFORD

CONTAINS SCHMITT (W) 432 A

INTEREST OFFICE

432 B. KIRKWOOD H.S.  
BIRMINGHAM, ALA.

RECEIVED

RECEIVED FROM THE

Dec 7  
Dec 4  
Dec 2



1  
66-520

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 12248 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12248

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ANDREW Louis LANG 2. DATE AND HOUR PRONOUNCED DEAD December 2, 1966 6:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

110 N. Montford

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH Jan. 27, 1907 9. AGE (In years last birthday) 59 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 10B. KIND OF BUSINESS OR INDUSTRY Donnelly Outdoor Adv. Co. 11. BIRTHPLACE (State or foreign country) Balto, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Louis Lang 14. MOTHER'S MAIDEN NAME Mary Everist

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. 212-07-1529 17. INFORMANT (nee Jackson) Florence Lang ADDRESS #24 110 N. Montford Ave.

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Traumatic Injuries.  
DUE TO

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Yes 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Building 21C. WHERE DID INJURY OCCUR? 2117 Edmondston Avenue

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12 1 '66 A 21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? Fell from roof while changing sign.

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Charles S. Petty

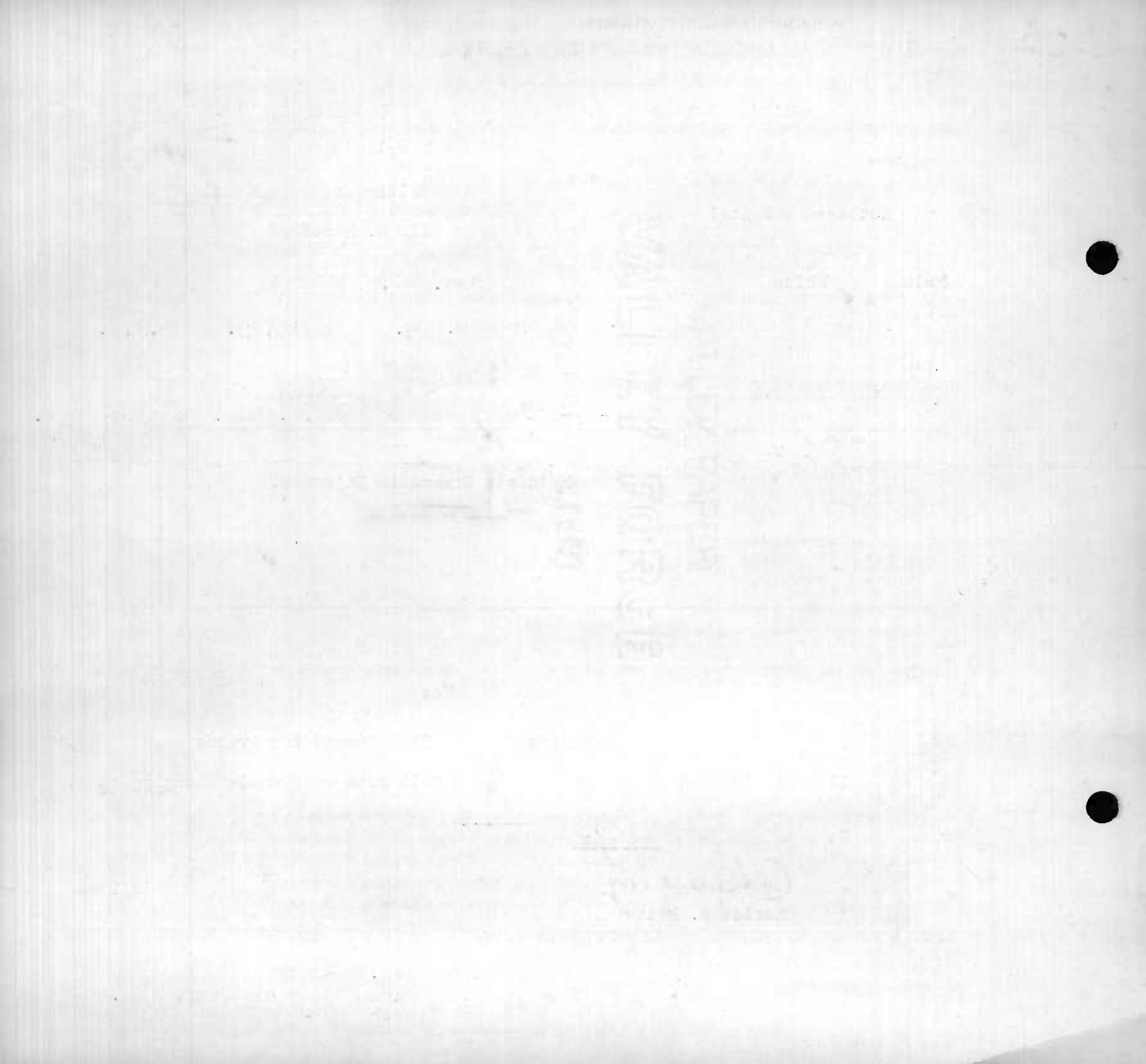
M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
12/2/66

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 12/6/66 23C. NAME of CEMETERY or CREMATORY Moreland Memorial Cem. 23D. LOCATION (City, town, or county) (State) Maryland

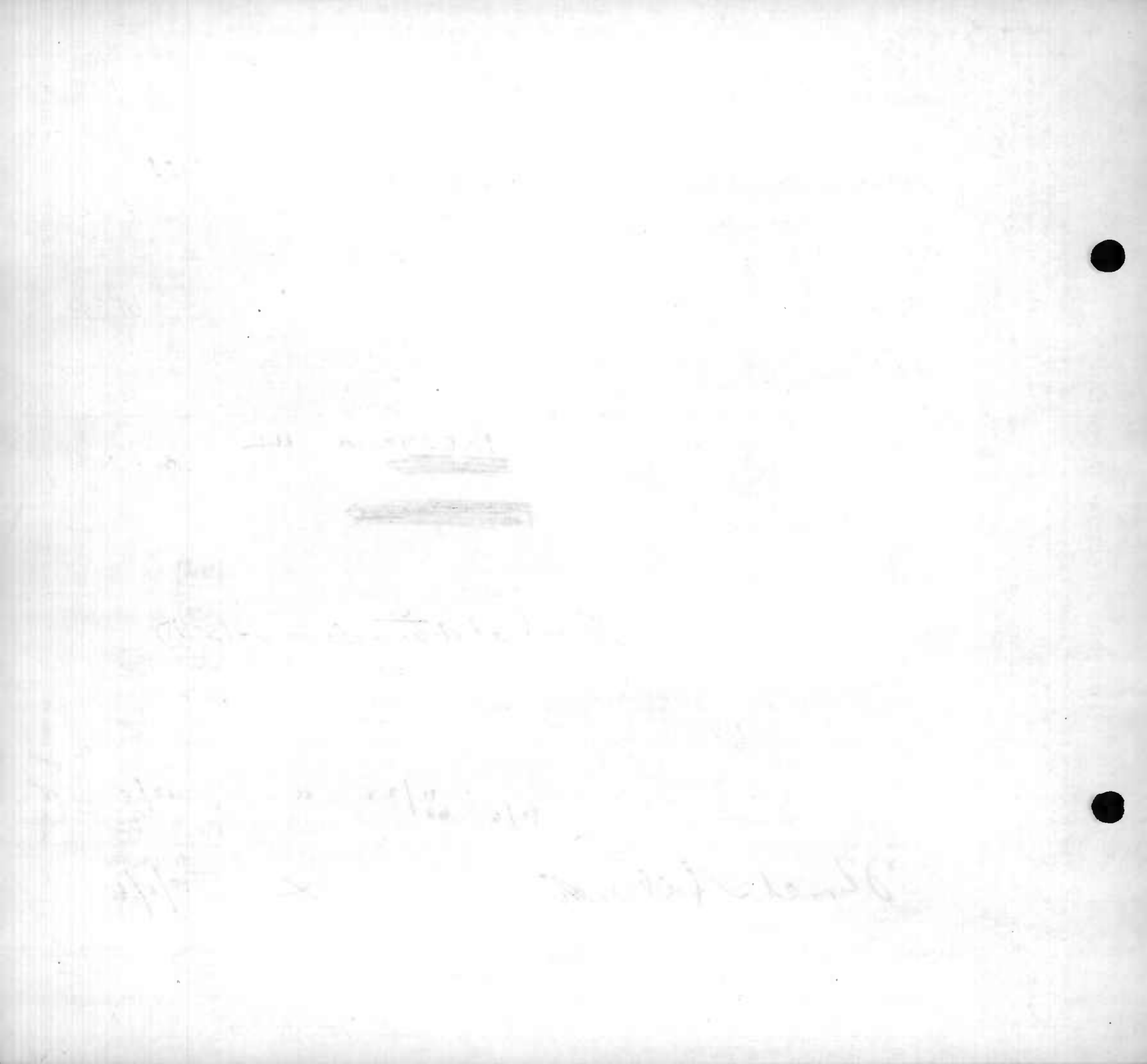
24A. DATE REC'D BY HEALTH DEPT. DEC 8 1966 24B. NAME OF REGISTRAR Robert E. Farkner 24C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 2601-03-05 E. Madison Street #5



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

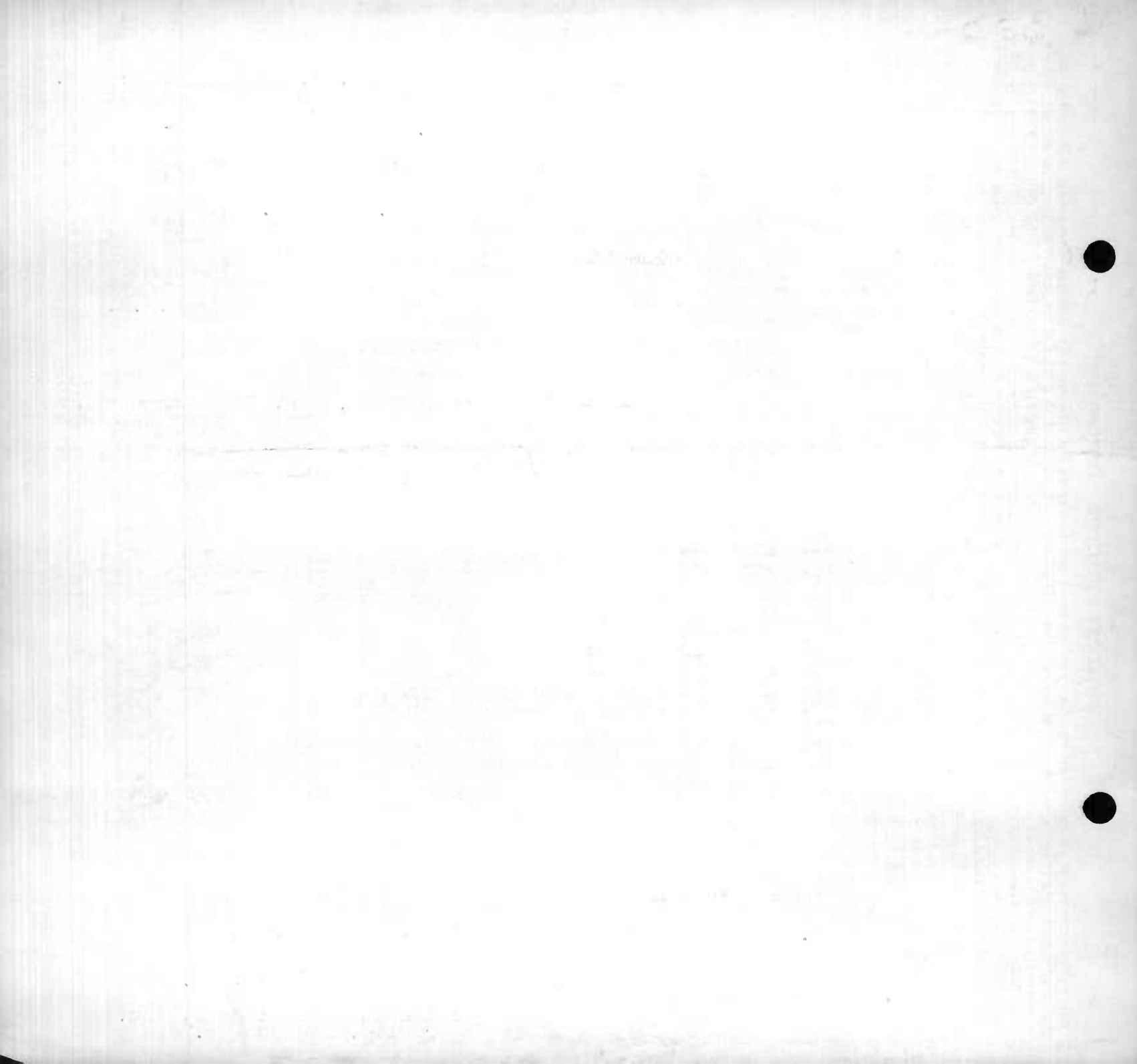
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12249</u>	
BIRTH NO. <u>66 12249</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Parlett, George Thomas</u>		2. DATE AND HOUR OF DEATH <u>12-6-66 16:15 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL Hospital</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE City</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>2915 ERDMAN Ave</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUCA.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>07-18-80</u>	9. AGE (in years last birthday) <u>86</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>- - - - -</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hecht Co</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JACKSON C. Parlett</u>		14. MOTHER'S MAIDEN NAME <u>MARIA Gager</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-923</u>		17. INFORMANT <u>Mrs. Bertha Raver</u> ADDRESS <u>2915 ERDMAN Ave</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONIA - LLL</u>		CAUSE OF DEATH (A) DUE TO <u><del>Ascaris</del></u> (B) DUE TO <u><del>Ascaris</del></u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>about 10 days</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized Arteriosclerosis - ASCVD</u>					
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>11/25</u> 19 <u>66</u> to <u>12/6</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>12/6</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Funeral Home</u>		23B. DATE SIGNED <u>12/6/66</u>		23C. PHYSICIAN'S NAME (Type) <u>—</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/9/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>	
25C. FUNERAL DIRECTOR <u>Schimmunek Funeral Home, Inc.</u>		25D. ADDRESS <u>23331 Brehms Lane</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12250</u>	
BIRTH NO. <u>66 12250</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LOUISE ANNA VITAK</u>		2. DATE AND HOUR OF DEATH <u>Dec. 4, 1966</u>   <u>8:30 a.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Gould Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>21205</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>702</u> <u>907 N. Rose St.</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> (specify)	8. DATE OF BIRTH <u>1/20/1888</u>	9. AGE (in years lost birthday) <u>78</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis Dousa</u>		14. MOTHER'S MAIDEN NAME <u>unknown Anna Czech</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-22-2413</u>		17. INFORMANT <u>Frank Vitak, son, 7906 Langdon Lane</u>	
18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Hyper-nephroma</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1966</u> to <u>12-4-</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 3, 1966</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lynn Krause</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Louis Krause</u>		23D. ADDRESS <u>11 E. Chase Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/7/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>R. E. E. Talley</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>	
				ADDRESS <u>2601 E. Madison St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-46		66 12251		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12251	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED <i>GEORGE TYLER</i>			
2. DATE AND HOUR OF DEATH <i>12/5/66 5:15 P.M.</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lincoln Memorial Nursing Home, 27 N. Carey St. Balto. Md.</i>				A. STATE <i>Maryland</i> B. COUNTY <i>Balto Co.</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Towson, Md.</i>				D. STREET ADDRESS (If rural, give location) <i>128 E. Chesapeake Ave</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>10-21-1888</i>	9. AGE (In years, last birthday) <i>78</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Factory</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Frank Tyler</i>				14. MOTHER'S MAIDEN NAME <i>Annice Parter</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>2201-8379</i>		17. INFORMANT ADDRESS <i>Joan Jones - 3025 Southland Pl.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>157X I</i>				CAUSE OF DEATH (A) DUE TO <i>CARCINOMA OF PANCREAS WITH LIVER METASTASIS</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/30/66</i> 19 to <i>12/5/66</i> 19, that (I) (we) last saw the deceased alive on <i>12/5/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Harris Sennaline M.D.</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>HARRIS SENNALINE M.D.</i>				23D. ADDRESS <i>930 WHITEHORN ST, TOWSON, MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12/9/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Pleasant Rest</i>		24D. LOCATION (City, town, or county) (State) <i>Towson, Balto. Co. Md.</i>	
25A. DATE REC'D. BY HEALTH DEPT. <i>DEC 8 1966</i>		25B. NAME OF REGISTRAR <i>R. B. E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Wm. P. Chaturman</i>		25D. ADDRESS <i>1701 Mt. Coddin</i>	

Chairman of the Board  
and Chief Executive

10/1/10

11/30/10

12/1/10

James B. Thompson  
President

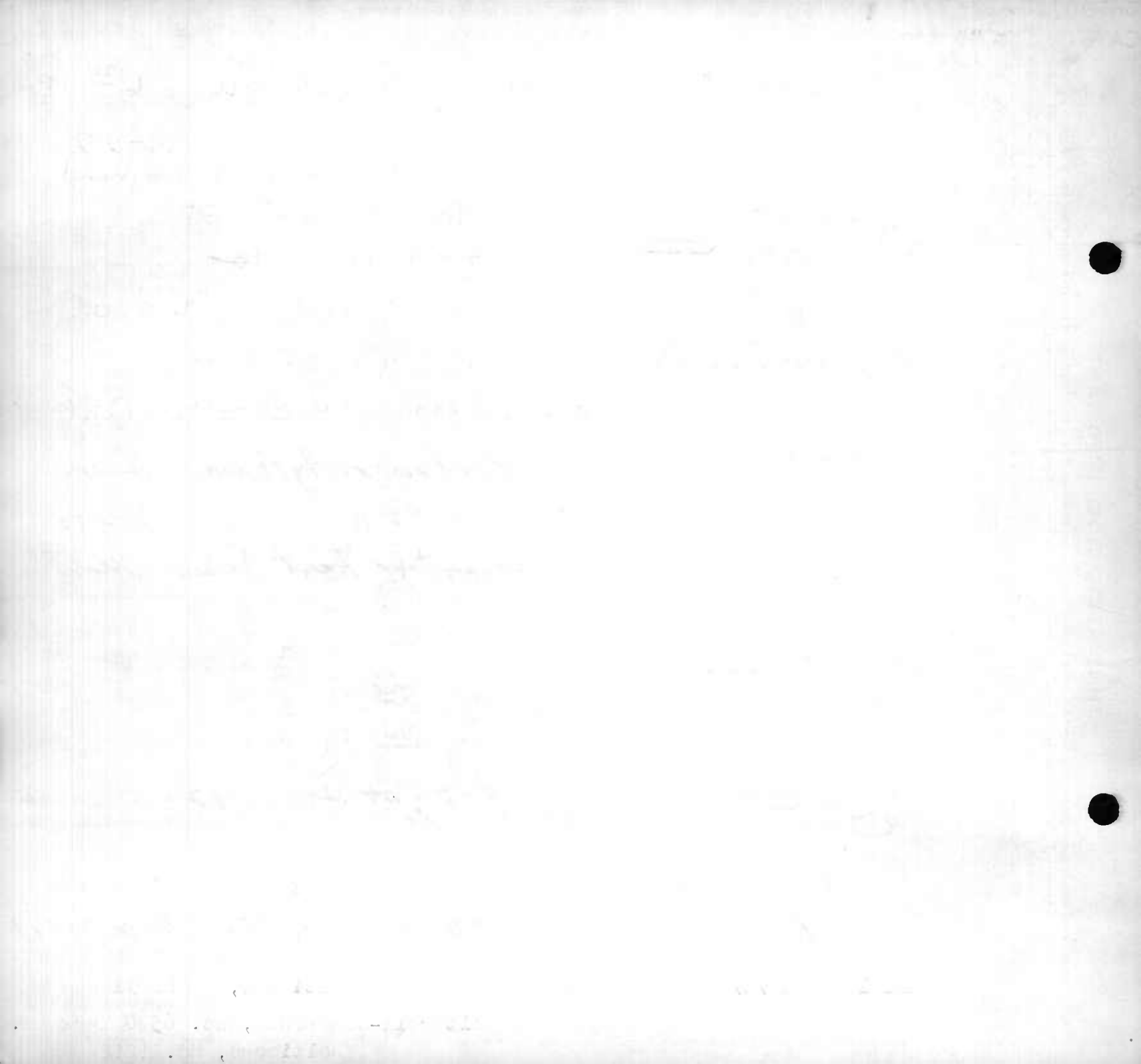
10/1/10



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

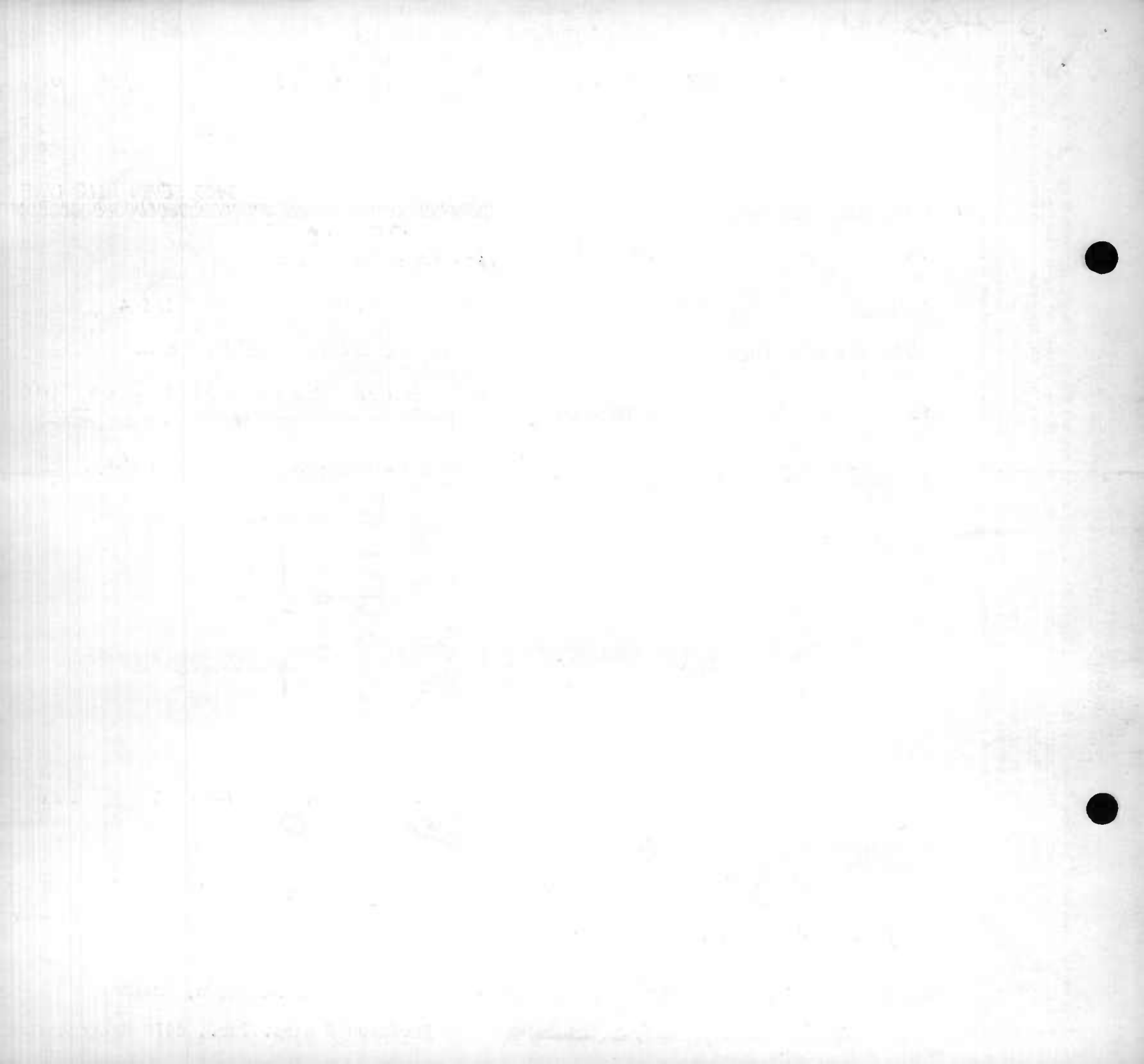
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12252	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>Baxter Marjory (Mrs)</b>		2. DATE AND HOUR OF DEATH <b>Dec. 5, 1966 6:20 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>91 Keswick</b>		A. STATE <b>Keswick</b> B. COUNTY <b>13-07</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Maryland</b>			
		D. STREET ADDRESS (If rural, give location) <b>700 W. 40th St.</b>			
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH <b>4-8-73</b>	9. AGE (In years last birthday) <b>93</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
13. FATHER'S NAME <b>John Ross McLean</b>		14. MOTHER'S MAIDEN NAME <b>Mary McGilvery</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218 46-2249</b>		17. INFORMANT ADDRESS <b>Margaret P. Hurdley R.O. - Keswick</b>	
18. <b>483.1 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Cardiac arrhythmia</b>		Interval Between Onset and Death <b>Hours</b>	
ANTECEDENT CAUSES		(B) DUE TO <b>AS CVD</b>		<b>Years</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO <b>Congestive heart failure</b>		<b>Months</b>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>8-3-64</b> to <b>12-5-66</b> that (I) <u>(we)</u> last saw the deceased alive on <b>12-5-66</b> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above <u>(I)</u> <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.					
23A. SIGNATURE <b>RK Gundry</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-6-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>RK GUNDRY</b>		23D. ADDRESS <b>2 W University Pkwy, Balto 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/8/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld, Inc. 6500 York Rd. Baltimore, Md. 21212</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12253</span>	
100 66 12253				CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: right;">66 12253</span>			M.E. CASE NO.		
1. NAME OF DECEASED (Type or Print) <b>Harold BACK</b>			2. DATE AND HOUR OF DEATH <b>12-5-66 7:30 p.m.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Levindale Aged Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 27-20</b> D. STREET ADDRESS (If rural, give location) <b>3903 SEVEN MILE LANE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>11-15-1894</b>	9. AGE (In years lost birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>upholstery</b>		11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>NORBERT Back</b>		
14. MOTHER'S MAIDEN NAME <b>GISELLA ZEISEL</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>Unknown</b>			17. INFORMANT <b>Mrs. Edith Back</b>		
ADDRESS <b>3903 Seven Mile Lane</b>			18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Parkinson's Disease</b>			<b>2 yrs.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>6-20-1966</b> to <b>12-5-1966</b> , that (1) (we) last saw the deceased alive on <b>12-5-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose Ardaiz</b>				23B. DATE SIGNED <b>12-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose ARDAIZ</b>				23D. ADDRESS M.D. <b>5912 Cross Country Blvd. Baltimore Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/7/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Chevera</b>	
24D. LOCATION (City, town, or county) (State) <b>Randallstown, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>			
25B. NAME OF REGISTRAR <b>Dr. E. J. Fink</b>		25C. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12254</u>	
BIRTH NO. <u>66 12254</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Israel Svidgall</u>			2. DATE AND HOUR OF DEATH <u>12/5/66</u> <u>12 NOON</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u> <u>42</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3808 Woodbine Ave.</u> # <u>7</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>[REDACTED]</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Abraham Svidgall</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u> ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. 1</u>		
16. SOCIAL SECURITY NO. <u>218-03-7129</u>			17. INFORMANT <u>Mrs. Rebecca Svidgall, 3808 Woodbine Avenue</u> #		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD</u>			(C) DUE TO		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>12/4/66</u> 19 <u>66</u> to <u>12/5</u> 19 <u>66</u> , that (we) last saw the deceased alive on <u>12/5</u> 19 <u>66</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Allan S. Rudolph</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>12-5-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Allan S. Rudolph</u> M.D.				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/6/66</u>		24C. NAME of CEMETERY or CREMATORY <u>(Anshe Emunah) - Aitz Chaim</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>			

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General Hospital of the Forces

Medical Staff

~~Medical Staff~~

1942

General Hospital

RECORD

Allen & G. L. L.  
Allen & G. L. L.

10-2-42  
2 of 10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 12255	
BIRTH NO. 66 12255		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CRESTON M. SMITH</b>		2. DATE AND HOUR OF DEATH <b>DEC. 5, 1966 12 35 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE 29, MD.</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>12-10-91</b>	
9. AGE (In years last birthday) <b>74</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Asst. Treas.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Banking UNKNOWN</b>			
13. FATHER'S NAME <b>UNKNOWN George Smith</b>				14. MOTHER'S MAIDEN NAME <b>MARLETTA MARTIEN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-01-9123</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE</b>			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarct</b>				(A) DUE TO			
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-4-1966</b> to <b>12-5-1966</b> , that (I) (we) last saw the deceased alive on <b>12-5-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>DR. ESTHER EDERY</b>				23B. DATE SIGNED <b>12/5/66</b>		23C. PHYSICIAN'S NAME (Type) <b>DR. ESTHER EDERY</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-8-1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Howard Strong</b>		25D. ADDRESS <b>307 W North Ave</b>	

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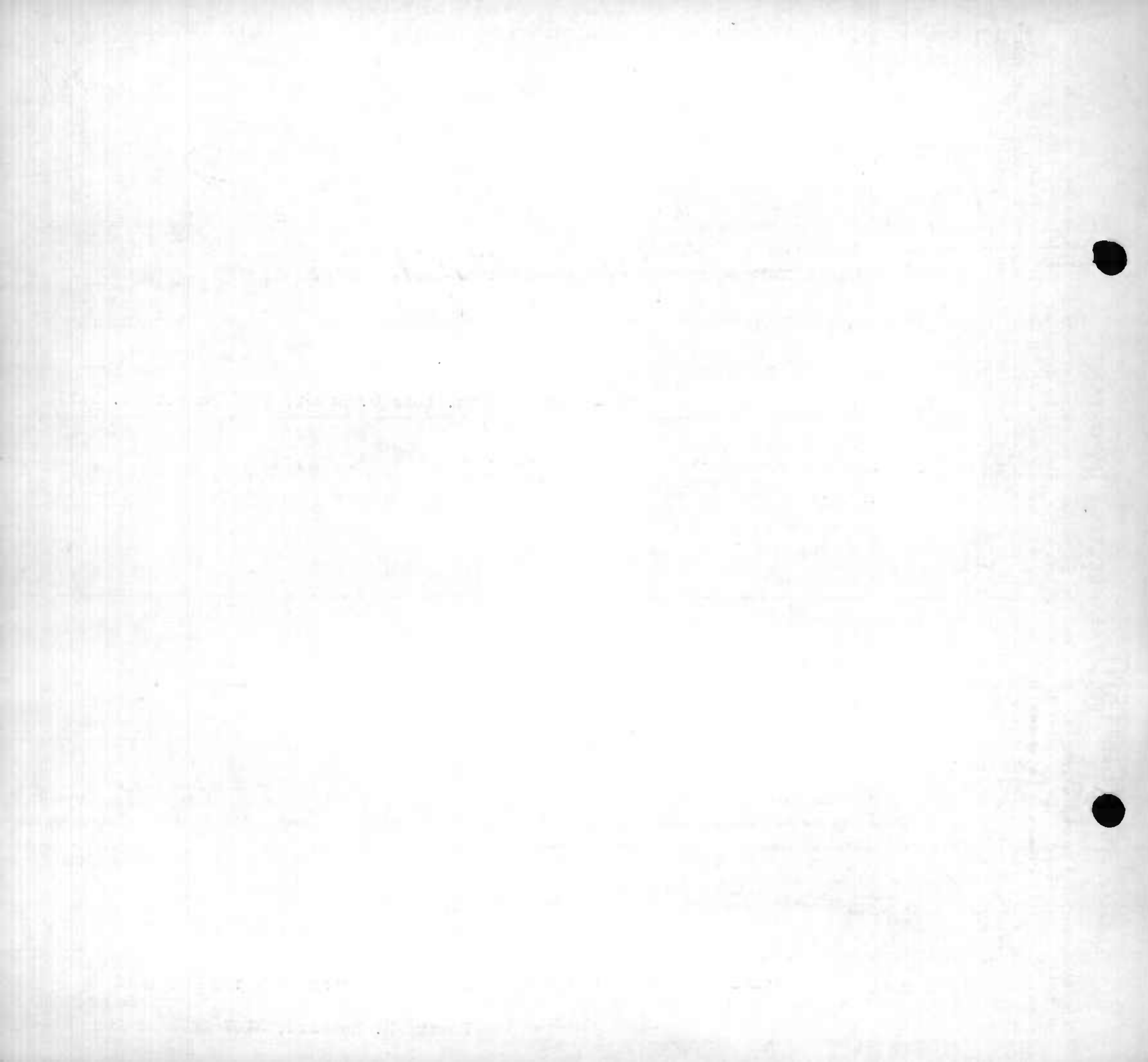
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# FUNERAL DIRECTOR: IMPORTANT

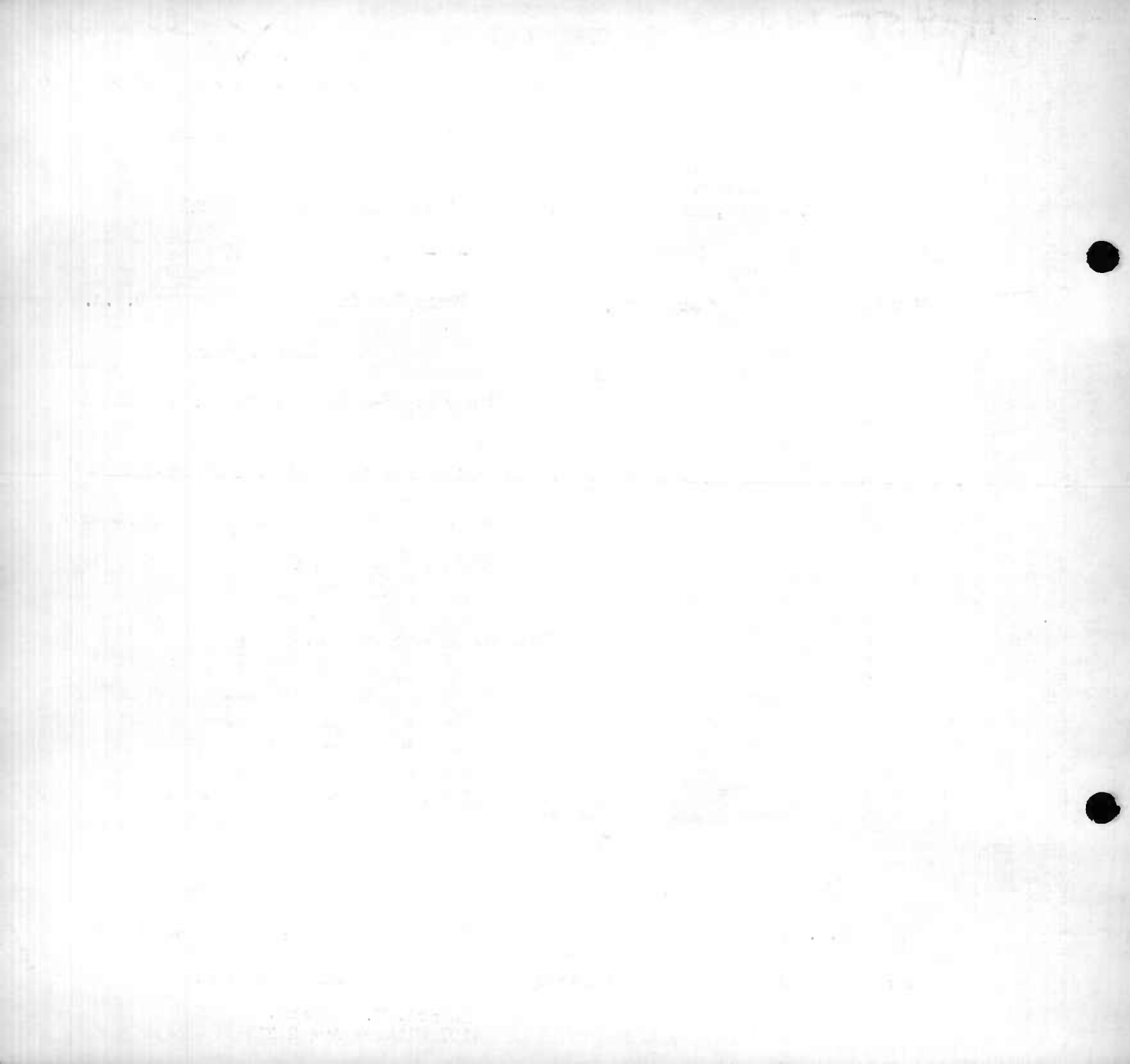
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department	
BIRTH NO. 66 12256				Registered No. 66 12256	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Howard C. Bauer			2. DATE AND HOUR OF DEATH 12/4/66 8:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt.		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location) Maryland General Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt.		
D. STREET ADDRESS (If rural, give location) 2401 Banger St.			5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		
8. B. DATE OF BIRTH 4/18/24 9. AGE (In years last birthday) 42 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patrolman 10B. KIND OF BUSINESS OR INDUSTRY Balt. City Police 11. BIRTHPLACE (State or foreign country) Balt., Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Frederick G. Bauer 14. MOTHER'S MAIDEN NAME Verna Thompson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 219-16-3272 17. INFORMANT ADDRESS Mrs. Lois O. Bauer, 2401 Banger St. 21230			18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
19. 420.1 I CAUSE OF DEATH (A) Acute Myocardial Infarction (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 5 Hours		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 12/3/66 to 12/4/66, that (we) last saw the deceased alive on 12/4/66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard du Buy M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 12/4/66	
23C. PHYSICIAN'S NAME (Type) Bernard du Buy M.D.				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-1966		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) Howard County, Maryland		24E. STATE (State)		24F. DATE REC'D BY HEALTH DEPT. DEC 8 1966	
25A. NAME OF REGISTRAR Robert E. Fickens		25B. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave 21229		25C. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12257	
CERTIFICATE OF DEATH					
BIRTH NO. 455 66 12257		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>HALLMAN, Albert</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co.</i>		2. DATE AND HOUR OF DEATH <i>12 / 2 / 66</i> <i>9:40 P.M.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>53-00</i>		D. STREET ADDRESS (If rural, give location) <i>324 Townsend Road 21221</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>Married</i>	8. DATE OF BIRTH <i>3-26-1907</i>	9. AGE (In years lost birthday) <i>59</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Forman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Martin Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Roland</i>		14. MOTHER'S MAIDEN NAME <i>Kate Rayburn</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Avenue 21224</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Acute Myocardial Infarct</i> DUE TO (B) <i>Coronary Insufficiency</i> DUE TO (C) <i>ASCVD, HCVD</i>		INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> <i>unknown</i> <i>5-6 yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic Lung disease</i>		19A. DATE OF OPERATION <i>0 5</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>0</i>	
20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/22/66</i> 19 <i>66</i> to <i>12/2</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/2</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>S.W. Douglas, III</i> (III) M.D.		23B. DATE SIGNED <i>12/2/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>S.W. Douglas (III)</i>		23D. ADDRESS M.D. <i>4940 Eastern Avenue, Baltimore, Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12/6/66</i>	24C. NAME OF CEMETERY or CREMATORY <i>Union Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Statington, Pa.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Howard. H. Hubbard.</i> <i>4107 Wilkens Ave 21229</i>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12258</b>	
BIRTH NO. <b>66 12258</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>RUTH EDNA BERGEN</b>		2. DATE AND HOUR OF DEATH <b>12-3-66</b>   <b>2:00AM</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> 8. COUNTY <b>HOWARD</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ELLICOTT CITY</b> D. STREET ADDRESS (If rural, give location) <b>426 MT. HEBRON DR.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL WILKENS &amp; CATON AVES. BALTIMORE 29, MD.</b>		(If not in hospital or institution, give street address or location)			
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>2-15-95</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>JOHN WILHELM (DEC'D)</b>		14. MOTHER'S MAIDEN NAME <b>IDA WISNES HIGGINS (DEC'D)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>217 34 7023</b>		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS-WILKENS &amp; CATON AVES</b>	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>ISCVD</b> (B) DUE TO <b>Myocardial Infarction</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 28</b> 19 <b>66</b> to <b>DECEMBER 3</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>DECEMBER 3</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>DEC. 3, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. WEISS, M.D.</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL - BALTO., 21229, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-6-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION <b>3801 Frederick Ave. Balto., Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>		24F. NAME OF REGISTRAR <b>R. E. E. Jr.</b>	
24G. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>		24H. NAME OF REGISTRAR <b>R. E. E. Jr.</b>		24I. FUNERAL DIRECTOR <b>Howard H. Hubbard Funeral Home Balto., Md.</b>	

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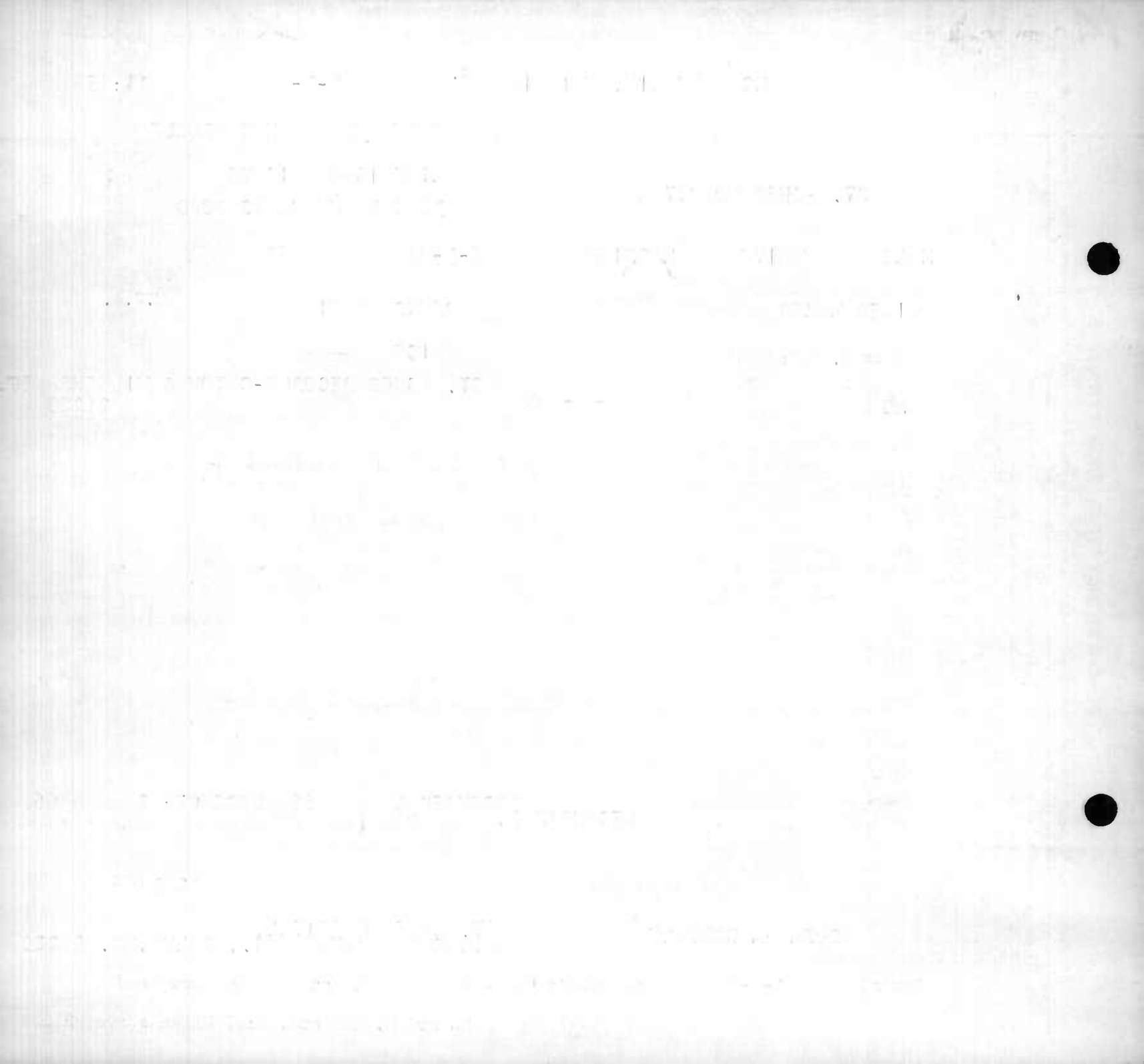
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>66 12259</u>
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>  <b>M.E. CASE NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <span style="margin-left: 100px;"><b>MC LAUGHLIN, WILLIAM C.</b></span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <div style="display: flex; justify-content: space-between;"> <span><b>12-3-66</b></span> <span><b>11:15A</b></span> </div> </div> </div>						
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <b>40 ST. AGNES HOSPITAL</b> </div> <div>                     (If not in hospital or institution, give street address or location)                 </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <b>MARYLAND</b> </div> <div> <b>B. COUNTY</b>  <b>ANNE ARUNDEL</b> </div> </div>			
<b>5. SEX</b> <b>MALE</b>			<b>6. RACE</b> <b>WHITE</b>		<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>MARRIED</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>BOILER MAKER</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>8. DATE OF BIRTH</b> <b>6-3-06</b>	<b>9. AGE</b> (In years last birthday) <b>60</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>PENNSYLVANIA</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Luther E. McLaughlin</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>ALICE Barrett</b>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>187-03-1095</b>		<b>17. INFORMANT</b> <b>ST. AGNES RECORDS-CATON &amp; WILKENS</b> <b>21229</b>		
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div> <b>(A) DUE TO</b>  <i>Intra-cerebral hemorrhage</i>   <b>(B) DUE TO</b>  <i>Meningioma left eye</i>   <b>(C)</b> </div> <div> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div>						
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>						
<b>19A. DATE OF OPERATION</b> <b>2</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>Yes</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>yes</b>		
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>DECEMBER 2</b> <b>19 66</b> <b>to</b> <b>DECEMBER 3</b> <b>19 66</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>DECEMBER 3</b> <b>19 66</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>						
<b>23A. SIGNATURE</b> <i>S. Korbuly</i>				<b>23B. DATE SIGNED</b> <b>12/3/66</b>		
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>SUSANNA KORBULY</b>				<b>23D. ADDRESS</b> <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE., BALTO, MD. 21229</b>		
<b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>12-6-1966</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Meadowridge Cemetery</b>		
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Howard County, Maryland</b>						
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 8 1966</b>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Farley</i>		<b>25C. FUNERAL DIRECTOR</b> <b>Howard H. Hubbard, 4107 Wilkens Ave, 21229</b>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12260		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 12260	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <u>Hawkins Samuel Edward SR.</u>		2. DATE AND HOUR OF DEATH <u>Dec. 2, 1966</u> <u>8</u> <u>P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 Franklin Square Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>8-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3214 Ravenwood Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>3-15-9K</u>	9. AGE (In years, lost birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - CLOTHING CUTTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Howard Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Martha Carroll</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>212 072755</u>		17. INFORMANT <u>Hospital chart</u>		ADDRESS	
18. <u>332X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>CEREBRAL INFARCTION INVOLVING BOTH BASAL</u> (B) DUE TO <u>GLANGLIA</u> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 18</u> 19 <u>66</u> to <u>Dec. 2</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 2</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. B. Sel</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Ki Bum Lee</u>		23D. ADDRESS <u>Franklin Square Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>12/6/66</u>	24C. NAME OF CEMETERY or CREMATORY <u>PARK WOOD CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>PARKVILLE MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1966</u>		25B. NAME OF REGISTRAR <u>John E. Finkbeiner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>ULLRICH FUNERAL HOME 4216 DEANR.</u>	

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12-11-11  
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12261		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12261	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MATTIE FLORENCE WRYE</b>		2. DATE AND HOUR OF DEATH <b>12-3-66 7<sup>10</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO 53-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 MD GEN HOSPITAL BALTO., MD</b>		D. STREET ADDRESS (If rural, give location) <b>7862 ST MONICA DRIVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>09-10-79</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN W. PRINELL</b>		14. MOTHER'S MAIDEN NAME <b>SALLY DAVIS</b>		17. INFORMANT ADDRESS <b>Kenneth R Koskenen MD</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.			
18. <b>493X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>DENYDRATION + MALNUTITION</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET before DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-3-66</b> 19 to <b>12-3</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-3</b> 19 <b>66</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kenneth R Koskenen</b> M.D.		23B. DATE SIGNED <b>12-3-66</b>		23C. PHYSICIAN'S NAME (Type) <b>KE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/6/66</b>		24C. NAME of CEMETERY or CREMATORY <b>MEADOW RIDGE PARK</b>	
24D. LOCATION (City, town, or county) <b>DORSEY MD</b>		24E. FUNERAL DIRECTOR <b>Wm GEN Hospital BALTO. MD</b>		24F. ADDRESS <b>WILKIN FUNERAL HOME DUNDALK MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkema</b>		25C. FUNERAL DIRECTOR <b>WILKIN FUNERAL HOME DUNDALK MD</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12262		Baltimore City Health Department		Registered No. 66 12262	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>KELLAND; Emma Haman</b>			2. DATE AND HOUR OF DEATH <b>12-6-66 11 45 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #12 53-00</b> D. STREET ADDRESS (If rural, give location) <b>536 Walker Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-8-91</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>Thomas R. Haman</b>			14. MOTHER'S MAIDEN NAME <b>Annie Dutton</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-10-2027A</b>	17. INFORMANT <b>Wesley Kelland</b>		ADDRESS <b>536 Walker Ave Baltimore, Md.</b>
18. <b>204.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) <b>Acute Leukemia</b> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 months?</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>12-6-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>11-12-66</b> to <b>12-6-66</b> , that (2) (we) last saw the deceased alive on <b>12-6-66</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John R. Vaughn Jr.</b>				23B. DATE SIGNED <b>12-6-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN R. VAUGHN, M.D.</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/9/66.</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			

11-8-20

12-6-20

Residence, 2124 Madison Avenue

Maryland Baltimore

Baltimore

336 Walker Ave

10-8-21 72

Female White Married

Maryland

Annie Patton

Thomas R. Hannan

336 Walker Ave Baltimore

Married

No

Acute Leukemia

No

12-6-20

X

11-15-20

12-6-20

John R. V. Hoff

12-6-20

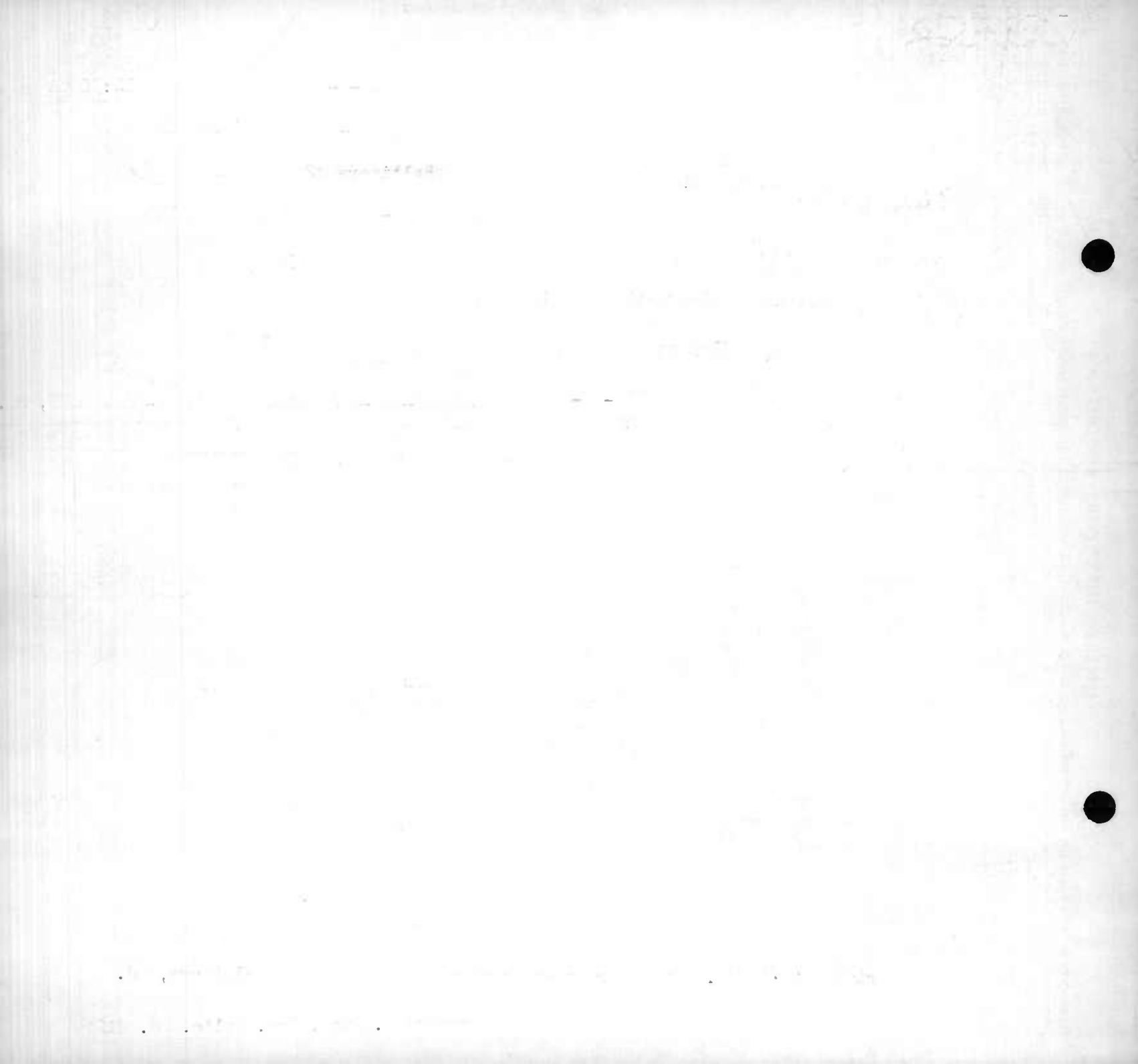
12-6-20

Received of the Baltimore City Health Department

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-23-82		66 12263		BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		Registered No. 66 12263	
BIRTH NO.		M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Vlangas, George</i>		2. DATE AND HOUR OF DEATH <i>12-7-66</i>   <i>12:30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE COUNTY</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #20 RURAL</i> <i>53-00</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 Baltimore, Md. 4940 EASTERN AVENUE</i>				D. STREET ADDRESS (If rural, give location) <i>Box 383 - Galloway Road #21220</i>					
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>12-15-82</i>	9. AGE (In years last birthday) <i>83</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Confectionery Store</i>		11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Louis Vlangas</i>				14. MOTHER'S MAIDEN NAME <i>Helen ?</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-18-3740A</i>		17. INFORMANT <i>#21224</i> ADDRESS <i>RECORDS-BCH-4940 EASTERN AVENUE-BALTIMORE, MD.</i>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>433.0 I</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Cardiac arrest</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>12/4</i> 19 <i>66</i> to <i>12/7</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/7</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Bruce M. Dow</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/7/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>Bruce M. Dow</i>		M.D.		23D. ADDRESS <i>Baltimore City Hospitals</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/12/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greek Orthodox Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>Balto. Md. 21214</i>			







This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY C. CLARKE

2. DATE AND HOUR OF DEATH

12-7-66

7:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

UNION MEMORIAL HOSPITAL

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO. #6

27-01

D. STREET ADDRESS (If rural, give location)

3719 RIDGECROFT ROAD

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

7-13-99

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

INSTALLER

10B. KIND OF BUSINESS OR INDUSTRY

Western  
ELECTRIC Co.

11. BIRTHPLACE (State or foreign country)

ALLENTOWN, PA.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

CHARLES I. CLARKE

14. MOTHER'S MAIDEN NAME

ALICE YOUNG

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

104-09-3479

17. INFORMANT

Mrs. Mary C. Clarke

ADDRESS

(Same)

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

Pulmonary edema

6 hr

(B) DUE TO

Acute Myocardial Infarct

6 hr

(C) DUE TO

Arteriosclerotic heart  
Disease

3 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-7 19 66 to 12-7 19 66.  
that (I) (we) lost saw the deceased alive on 12-7 19 66 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frank A. Carozza

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12-7-66

23C. PHYSICIAN'S  
NAME (Type)

FRANK A. CAROZZA

M.D.

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/10/66

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE RECD. BY HEALTH DEPT.

DEC 8 1966

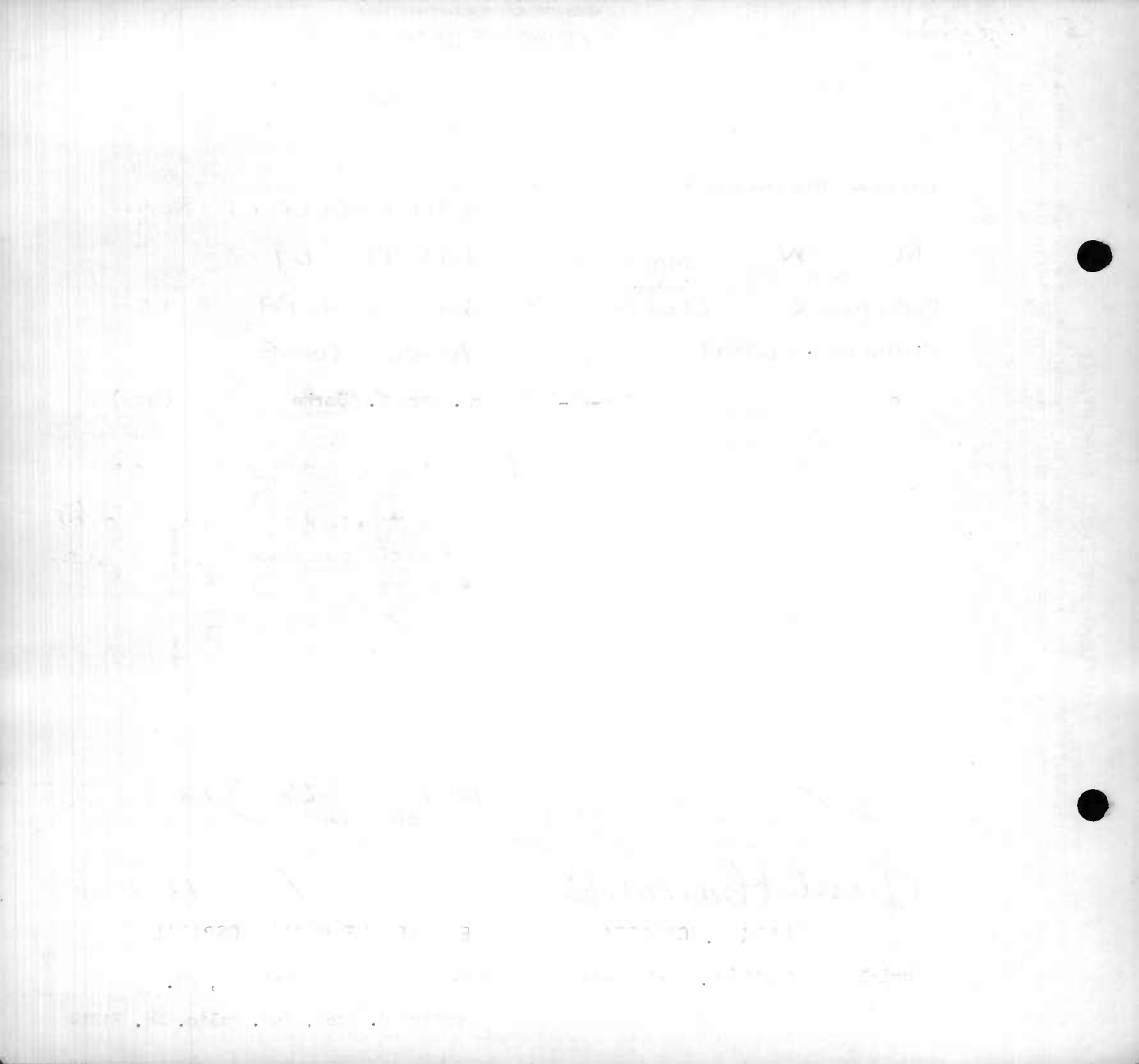
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Leonard J. Rueck, Inc. Balto. Md. 21214

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12265</u>	
BIRTH NO. <u>66 12265</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES M. KALUS</u>		2. DATE AND HOUR OF DEATH <u>12-7-66 10:20 AM</u> <u>10:20 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY Hospital</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 26-02</u>		
			D. STREET ADDRESS (If rural, give location) <u>4203 Sheldon Avenue</u>		
5. SEX <u>M</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct. 1, 1887.</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Martin Kalus</u>			14. MOTHER'S MAIDEN NAME <u>Mary Behounek</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-05-1816</u>	17. INFORMANT ADDRESS <u>Mrs. Stella Kalus (Same)</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cancer of lung with obstruction causing lung abscess</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Arteriosclerosis, Coronary Artery Disease</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Sept 20</u> 19 <u>66</u> to <u>Dec 7</u> 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>Dec 7</u> , 19 <u>66</u> and that in my <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (1) (We) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>John Gary Green</u> M.D.				23B. DATE SIGNED <u>Dec. 7, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>John Gary Green</u> M.D.				23D. ADDRESS <u>Mercy Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/10/66.</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Finken</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	

Case of lung cancer  
in the lung

Attested and signed  
Yes Yes

Dec 7

1892

1892

John G. Grier  
John G. Grier

## CERTIFICATE OF DEATH

Registered No.

66 12266

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

John Ford.

2. DATE AND HOUR OF DEATH

12/6/66 5:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)31 Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1510 School Street 21217

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

4-18-10

9. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Cornelius

14. MOTHER'S MAIDEN NAME

Ida

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

235-05-8314

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. I 177X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Gram negative sepsis  
and pneumonitis.

(B) DUE TO

Recurrent G.U. infection

(C) DUE TO

Carcinoma of the Prostate

INTERVAL BETWEEN  
ONSET AND DEATH

days

weeks

&gt; 1 year

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.Congestive heart failure,  
pulmonary metastases.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/4/66 to 12/6/66.  
that (I) (we) last saw the deceased alive on 12/6/66 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Terry Ersel Gagon

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/6/66

23C. PHYSICIAN'S  
NAME (Type)

Terry Ersel Gagon

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-10-66

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

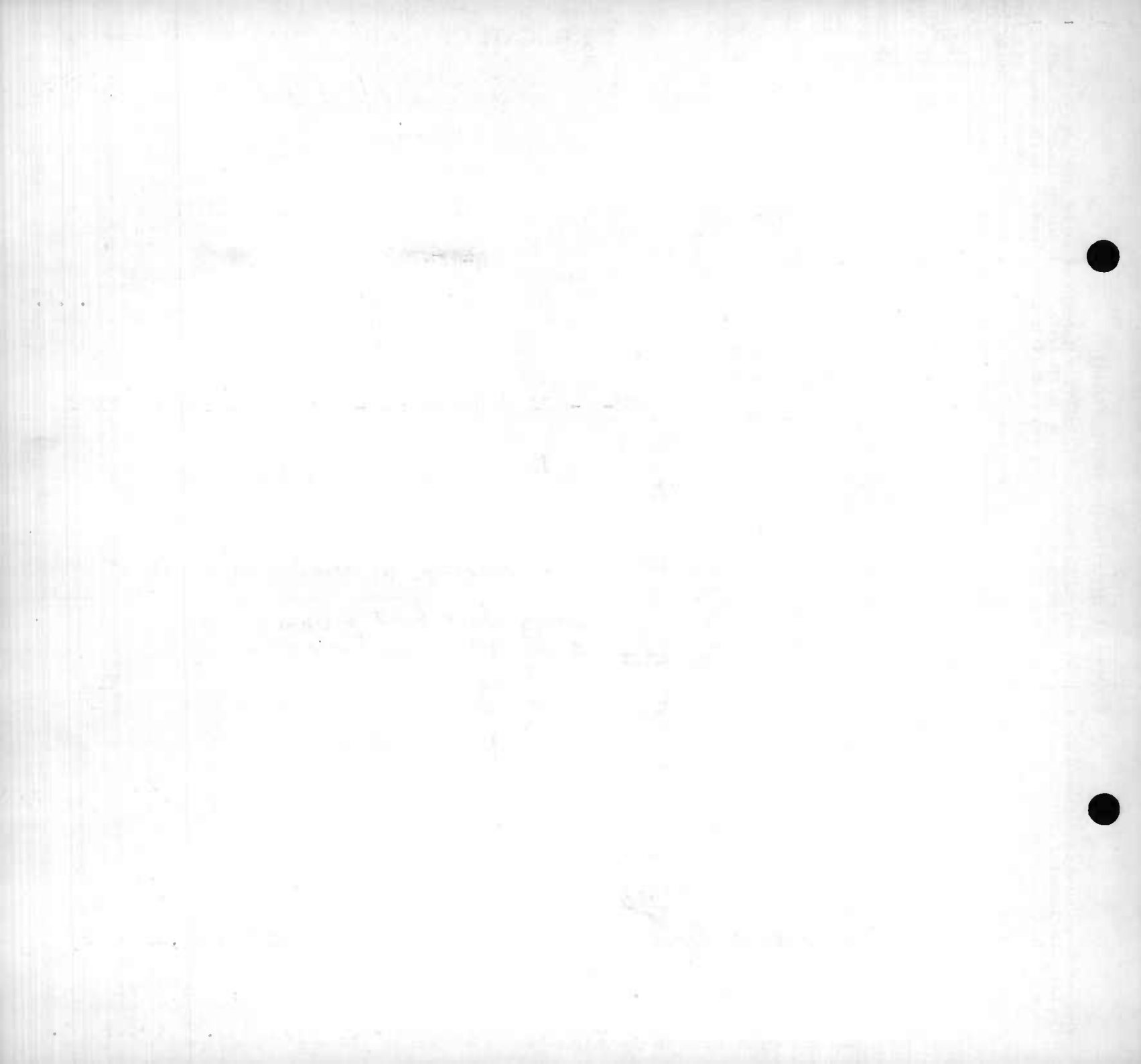
25C. FUNERAL DIRECTOR

ADDRESS

George Kelson 1348 N. Calhoun St.

FUNERAL DIRECTOR: IMPORTANT

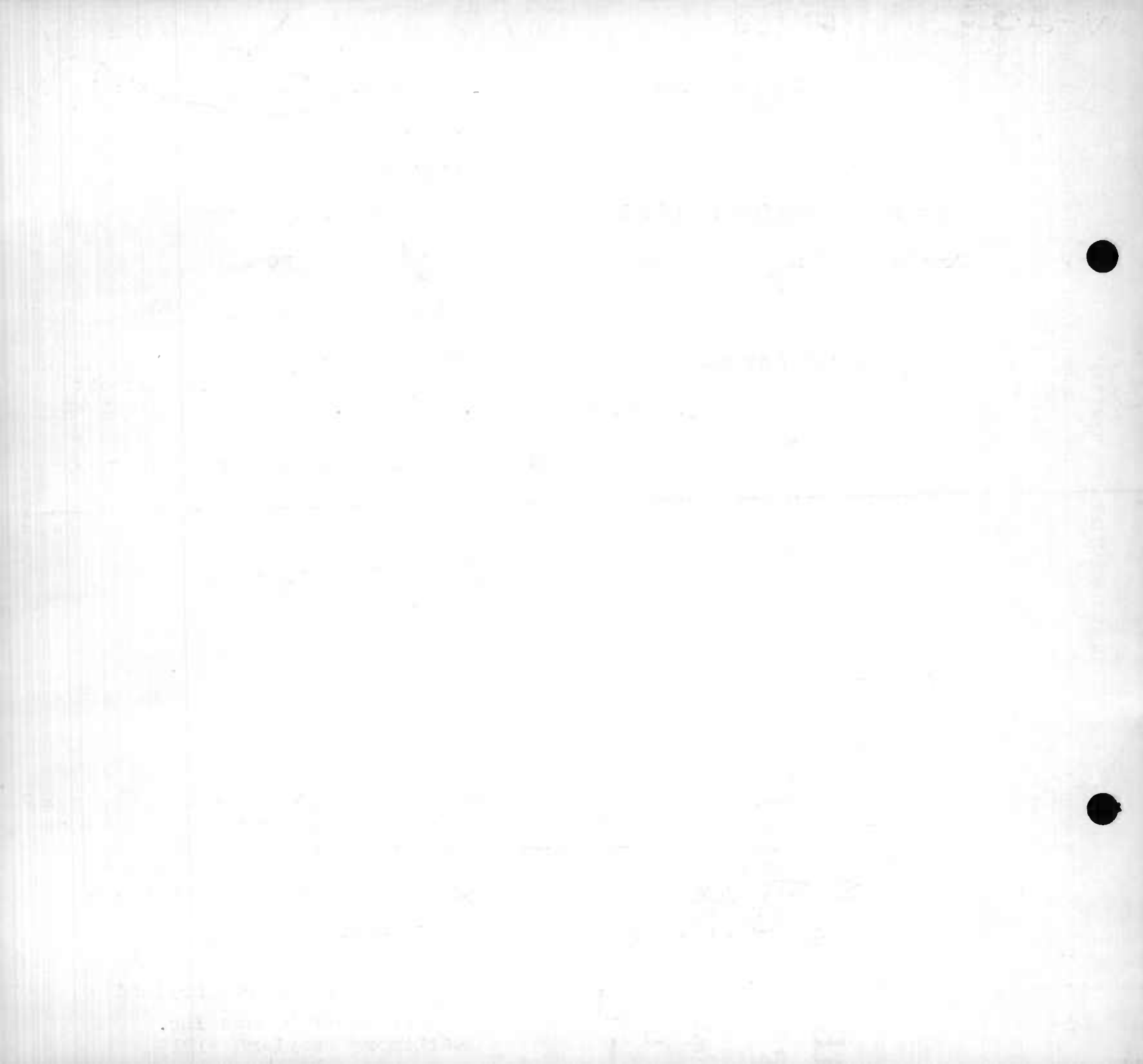
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12267		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12267	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Ida Mae Weis</b>			2. DATE AND HOUR OF DEATH <b>12/6/66 11:45 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>408 South Marlyn Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>9/4/1886</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Howard Stevens</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Arnett</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-32-8958</b>	17. INFORMANT ADDRESS <b>13405 Jane Avenue Detroit Michigan</b> <b>Mr. Howard E. Weis</b>		
18. <b>434.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>CARDIAC ARREST</b> DUE TO (B) <b>HEMORRHAGIC PANCREATITIS 2WKS</b> DUE TO (C) <b>CHF + ASCVD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN</b>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>12/1</b> 19 <b>66</b> to <b>12/6</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12/6</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>S. Mishkin</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/6/66</b>
23C. PHYSICIAN'S NAME (Type) <b>S. Mishkin</b>			23D. ADDRESS <b>JHH</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/9/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION <b>Baltimore Maryland</b>		24E. CITY, town, or county (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fickens</b>		25C. FUNERAL DIRECTOR <b>Henry Sander &amp; Sons Inc.</b>	
25D. ADDRESS <b>Baltimore Maryland 21213</b>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12268		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12268	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Kenly, Viola</i>			2. DATE AND HOUR OF DEATH <i>Dec 7, 1966 8:25 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home &amp; Hosp.</i>			A. STATE <i>Maryland</i>		
(If not in hospital or institution, give street address or location)			B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			8-05		
D. STREET ADDRESS (If rural, give location) <i>1913 McDonough St.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>6-27-1902</i>	9. AGE (In years last birthday) <del>XXX</del> 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland, Baltimore USA</i>	
13. FATHER'S NAME <i>Willie Amos William Amos</i>			14. MOTHER'S MAIDEN NAME <i>Anna Steinball</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>George Kenly</i>	
				ADDRESS <i>same</i>	
18. <i>260 X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) <i>Diabetic nephropathy</i>		<i>1942</i>	
ANTECEDENT CAUSES		(B) <i>Uremia due to A</i>		<i>unknown probably years</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Hyperkalemia due to B</i>		<i>1 day</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Congestive heart failure.</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <i>this hospital</i> ) attended the deceased from <i>11-12-66</i> to <i>12-7-66</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>12-7-66</i> and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. NANNUM</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-7-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>A. NANNUM</i>		23D. ADDRESS <i>Church Home &amp; Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12/10/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE MARYLAND</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>HENRY SANDER &amp; SONS INC.</i>	
				ADDRESS <i>BALTIMORE MARYLAND</i>	

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Q. HANNA

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12269				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		Registered No. 66 12269	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				WILLIAM FREDERICK MELLENDICK		Dec. 7 1966 6 <sup>00</sup> A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
38 UNIVERSITY HOSP.				Md.		Baltimore		Balt Co.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Catonsville 53-00			
				D. STREET ADDRESS (If rural, give location)		425 Academy Road			
5. SEX	6. RACE	7. <u>MARRIED</u> NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
M	W			4/28/44	72				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired						New Jersey		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
GEORGE MELLENDICK				ELIZABETH SCULLY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give woi or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				216-03-9935A		Mrs. William F. Mellendick		425 Academy Rd. - #28	
18. <u>260 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) Myocardial infarction					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO					
				(B) DIABETES MELLITUS					
				DUE TO					
				(C) DUPUYTREN'S CONTRACTURES					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
D									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>12/2</u> 19 <u>66</u> to <u>12/7</u> 19 <u>66</u> , that (1) <u>we</u> last saw the deceased alive on <u>12/6</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> (did not) view the body after death.									
23A. SIGNATURE				M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dora E. Colitor								12/7/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
				M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		12-10-66		New Cathedral Cem.		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 8 1966		Robert E. Farber		Witzke F.D.		4101 Edmondson Ave.			

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UNITED STATES

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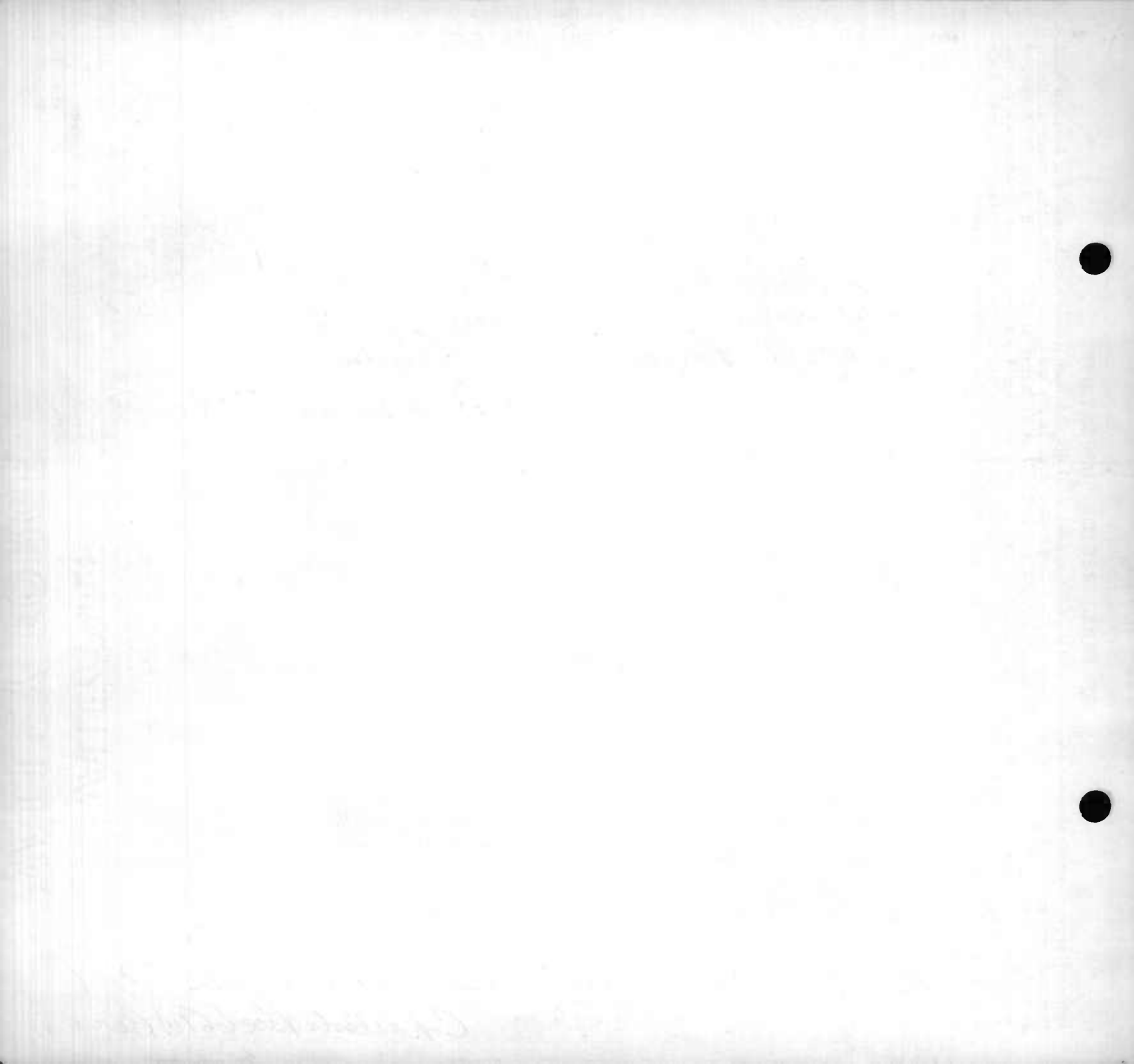
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				66 12270	
BIRTH NO. 66 12270				Registered No. _____	
M.E. CASE NO. _____				66 12270	
1. NAME OF DECEASED (Type or Print) <i>Wesley Purnell</i>			2. DATE AND HOUR OF DEATH <i>12/4/66 4:40 PM</i> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> <i>University of Maryland</i>			A. STATE <i>Md.</i> B. COUNTY <i>4-02</i>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			D. STREET ADDRESS (If rural, give location) <i>729 W. Saratoga</i>		
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>2/1/05</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>George Purnell</i>			14. MOTHER'S MAIDEN NAME <i>Linda</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-10-0513</i>	17. INFORMANT ADDRESS <i>Lena Purnell 729 W. Saratoga</i>		
18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>acute MI</i> DUE TO (B) <i>Diabetes, ? pneumonia</i> DUE TO (C) _____		
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William A. Saville M.D.</i>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <i>William A. Saville</i>			23D. ADDRESS <i>University Hospital, University of Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12/8/66</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles A. Rice 661 W. Barre St</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12271		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12271	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) BERTIE MC NAMARA		
2. DATE AND HOUR OF DEATH 12/2/66 7 <sup>20</sup> A M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 8-06			5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		
6. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			7. STREET ADDRESS (If rural, give location) 1707 EAST FEDERAL STREET		
8. SEX FEMALE	9. RACE NEGRO	10. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	11. DATE OF BIRTH 7-20-08	12. AGE (In years last birthday) 58	13. If Under 1 Yr. Months Days Hours Min.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		15. KIND OF BUSINESS OR INDUSTRY		16. BIRTHPLACE (State or foreign country) Md.	
17. FATHER'S NAME JESSE HILLIARD		18. MOTHER'S MAIDEN NAME MAUDE		19. CITIZEN OF WHAT COUNTRY? U.S.A.	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		21. SOCIAL SECURITY NO.		22. INFORMANT ADDRESS LEONARD MCNAMARA 1639 N. BROADWAY	
23. CAUSE OF DEATH 18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			24. (A) DUE TO GI bleeding 2 days (B) DUE TO Adeno carcinoma - site unknown 2 months (C) DUE TO		
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? (Yes or No) NO	
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
31. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		32. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		33. HOW DID INJURY OCCUR?	
34. I certify that (I) (this hospital) attended the deceased from 11/30/66 19 to 12/2 1966, that (I) (we) last saw the deceased alive on 12/2/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
35. SIGNATURE F. Ismael Beigi M.D.				36. DATE SIGNED	
37. PHYSICIAN'S NAME (Type) F. ISMAEL BEIGI				38. ADDRESS THE JOHNS HOPKINS HOSPITAL	
39. BURIAL CREMATION, REMOVAL (Specify) BURIAL		40. DATE 12-6-66		41. NAME of CEMETERY or CREMATORY ARBUTUS MEM. PARK ARBUTUS Md.	
42. DATE REC'D BY HEALTH DEPT. DEC 8 1966		43. NAME OF REGISTRAR Robert E. Fairbank		44. FUNERAL DIRECTOR JOSEPH KNIGHT 1639 N. BROADWAY	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 12272					CERTIFICATE OF DEATH					Registered No. 66 12272				
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Willie Ward</b>										<b>2. DATE AND HOUR OF DEATH</b> <b>12.6.66 4:45M</b>				
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>33 Johns Hopkins Hospital</b>										<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>MARYLAND</b> <b>B. COUNTY</b> <b>8-04</b> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> <b>D. STREET ADDRESS</b> (If rural, give location) <b>2105 EAST CHASE STREET</b>				
<b>5. SEX</b> <b>M</b>		<b>6. RACE</b> <b>N</b>		<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>			<b>8. DATE OF BIRTH</b> <b>8-1-04</b>		<b>9. AGE</b> (In years last birthday) <b>62</b>		<b>10. Under 1 Yr.</b> <b>Months: Days: Hours: Min.</b>			
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>3 Labor</b>					<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>North Carolina</b>					<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				
<b>13. FATHER'S NAME</b> <b>Roland Ward</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>LISA Copper</b>									
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					<b>16. SOCIAL SECURITY NO.</b> <b>223-03-1526</b>		<b>17. INFORMANT</b> <b>Willie Ward Same</b>					<b>ADDRESS</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>334X1</b> <b>Coma -- cardiac and resp arrest</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b>				
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>Essential hypertension</b>														
<b>19A. DATE OF OPERATION</b> <b>2</b>					<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>					<b>20A. AUTOPSY? (Yes or No)</b> <b>yes</b>				
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>					<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)					<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)				
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)					<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					<b>21F. HOW DID INJURY OCCUR?</b>				
<b>22. I certify that (I) (this hospital) attended the deceased from 12.2.66 19 to 12.6.66 19, that (I) (we) last saw the deceased alive on 12.6.66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>														
<b>23A. SIGNATURE</b> <b>Robert M. Winslow</b>										<b>23B. DATE SIGNED</b> <b>12/6/66</b>				
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Robert M. Winslow</b>										<b>23D. ADDRESS</b> <b>Johns Hopkins Hospital</b>				
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>24B. DATE</b> <b>12-11-66</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Richmond Cal</b>			<b>24D. LOCATION</b> (City, town, or county) (State) <b>Richmond Va</b>						
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 8 1966</b>			<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Fisher, M.D.</b>			<b>25C. FUNERAL DIRECTOR</b> <b>Walter J. Henry</b>			<b>ADDRESS</b> <b>Richmond Va</b>					

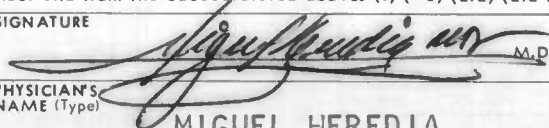
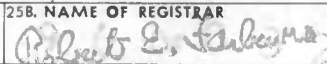
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 12273</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12273</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>BOYER, THOMAS ELLWOOD Sr.</b>			2. DATE AND HOUR OF DEATH <b>DECEMBER 5, 1966 11:10A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST. AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 27-18</b> D. STREET ADDRESS (If rural, give location) <b>5110 ARBUTUS AVE. 21227</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-1-27</b>	9. AGE (In years lost birthday) <b>39</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GLASS CO PITTSBURGH PLATE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>ELROY BOYER</b>			14. MOTHER'S MAIDEN NAME <b>PEARL CHANEY</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN Yes -WW II</b>		16. SOCIAL SECURITY NO. <b>217-20-4017</b>		17. SPERMANT ADDRESS <b>SP. XXXX AGNES HOSPITAL RECORDS</b>	
18. <b>190.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>metastatic melanoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO _____ (B) DUE TO _____ (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 29 1966</b> to <b>DECEMBER 5 1966</b> , that (I) (we) last saw the deceased alive on <b>DECEMBER 5 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  MIGUEL HEREDIA M.D.				23B. DATE SIGNED <b>12-5-66</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		<b>ST AGNES HOSPITAL, BALTO.MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-8-1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>3801 Frederick Ave. Balto. Md. 29</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12274</u>	
BIRTH NO. <u>66 12274</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Dorn, Marion E.</u>		2. DATE AND HOUR OF DEATH <u>December 6, 1966 3:54 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 25-31</u>	
		D. STREET ADDRESS (If rural, give location) <u>416 S Chapelgate Lane</u>			
5. SEX <u>✓</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-25-36</u>	9. AGE (In years last birthday) <u>30</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>First National Bank</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Dillard</u>		14. MOTHER'S MAIDEN NAME <u>Emily Day</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-34-1140</u>		17. INFORMANT <u>Mr. Griffith B. Dorn, Jr.</u>	
				<u>416 S. Chapelgate Lane Balto., Md. 29</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Malignant Melanoma 9 months</u>		CAUSE OF DEATH (A) DUE TO <u>metastatic malignant melanoma</u> (B) <u>malignant melanoma (removed from back.)</u> (C) <u>back.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years ago</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>August 25</u> 19 <u>66</u> to <u>December 6</u> 19 <u>66</u> , that (we) last saw the deceased alive on <u>August 6</u> 19 <u>66</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jose A Palancar</u>		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/6/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSE A PALANCAR</u>		23D. ADDRESS <u>BON SECOURS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12--9-66</u>	24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1966</u>		25B. NAME OF REGISTRAR <u>R. E. F. F. F.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	

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 and the second page contains a list of names.  
 The third page contains a list of names.

JOSE A PALANCA  
Rafael Palanca  
August 6 1966  
August 22 1966  
16 December 66

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12275	
BIRTH NO. 66 12275		CERTIFICATE OF DEATH		Registered No. 66 12275	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Edgar L. Evans.</i>		2. DATE AND HOUR OF DEATH <i>Dec 5th - 1966 2:45 A.M.</i>	
3. PLACE OF DEATH <i>IN</i> BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 27-05</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home &amp; Hospital</i> <i>35</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>6005 Burgess Ave (14)</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>9-27-05</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired (Crown-Cork Seal)</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>American</i>		13. FATHER'S NAME <i>Edgar S. Evans.</i>		14. MOTHER'S MARRIAGE NAME <i>Maggie C. Killmound</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-09-8006</i>		17. INFORMANT ADDRESS <i>Evelyn M. Evans - Same.</i>	
18. <i>470X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Pneumonia (Upper &amp; lower lob, @ upper lobe)</i> DUE TO (B) DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>ASCD &amp; old Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 28th</i> 19 <i>66</i> to <i>Dec. 5th</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec. 5th</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodelio M. Lim</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-5-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Rodelio M. Lim</i>		23D. ADDRESS <i>Church Home &amp; Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/8/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1966</i>			
25B. NAME OF REGISTRAR <i>Robert C. Altenburg, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Robert C. Altenburg-6009 Harford Rd. Funeral Home, Inc.</i>			

Edgar - 3 1/2

See 2-28-46

Church Home + Hospital

Baltimore

Male White married

9-27-02 61

Edwin (Groom - last seen)

Edgar 2. Evans

Maryland

Maggie C. Killmear

Evlyn M Evans - same

See 2-28-46

See 2-28-46



1  
w-420

66 12276

BALTIMORE CITY HEALTH DEPARTMENT

66 12276

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **MARY WALSH**

2. DATE AND HOUR PRONOUNCED DEAD  
December 3, 1966 10:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
**Union Memorial Hospital (DOA)**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY \_\_\_\_\_  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore 13-05**  
D. STREET ADDRESS (If rural, give location)  
**3027 Keswick Road**

5. SEX **Female**

6. RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)  
**Married**

8. DATE OF BIRTH  
**Aug 15, 1913**

9. AGE (In years last birthday) **53**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Housewife**

11. BIRTHPLACE (State or foreign country)  
**Scranton, Pa**

12. CITIZEN OF WHAT COUNTRY?  
**U.S.**

13. FATHER'S NAME  
**Eugene McColligan**

14. MOTHER'S MAIDEN NAME  
**Bridget Lawless.**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
**no**

16. SOCIAL SECURITY NO.  
**?**

17. INFORMANT  
**Michael P. Walsh.**

18. ADDRESS  
**3027 Keswick Road**

18. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
**Arteriosclerotic heart disease**  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
**2**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)  
**Yes**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  
**Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  
☐ UNDERLYING ☐ CONTRIBUTING

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** M.D.  
EXAMINER'S NAME (Type) **Charles S. Springate, M.D.**

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
**December 4, 1966**

23A. BURIAL CREMATION, REMOVAL (Specify)  
**Burial**

23B. DATE  
**12/7/66**

23C. NAME of CEMETERY or CREMATORY  
**Gardens Of Faith.**

23D. LOCATION (City, town, or county) (State)  
**827 N. Charles St. Balto, Md**

24A. DATE REC'D BY HEALTH DEPT.  
**DEC 8 1966**

24B. NAME OF REGISTRAR  
**Robert E. Fairbank**

24C. FUNERAL DIRECTOR  
**Austin G. Donovan**

24D. ADDRESS  
**3818 Roland**

VS 151-REV. 1/1/65

# 11

Aug 15, 1917

Seaton, Pa

Robert L. Lufers

Michael J. Lufers

WILLIAM

EDWARD

WILLIAM

Honorable

James McColgan

do

1917/18 Section of Sales

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.2em;">66 12277</span>	
BIRTH NO. <span style="font-size: 1.2em;">66 12277</span>							
M.E. CASE NO. <span style="font-size: 1.2em;">66 12277</span>							
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Mary C. Troyer</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12-4-66</span> <span style="font-size: 1.2em;">8:10</span> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">90 Ardleigh Nursing Home</span>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Balt. Co</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">53-00</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">5611 St. Marys Avenue</span>			
5. SEX <span style="font-size: 1.2em;">female</span>	6. RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7-2-1883</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">83</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">domestic</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">domestic</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">Matthew Brown</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Elizabeth Blouse</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">?</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Elizabeth V. Warren, 5611 St. Marys Av</span>		
18. <span style="font-size: 1.2em;">260X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Diabetes Mellitus</span> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">5 years</span>	
				(B) <span style="font-size: 1.2em;">Arteriosclerotic Cardio-vascular Disease</span> DUE TO			
				(C)		<span style="font-size: 1.2em;">15 Years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">April 1963</span> 19 to <span style="font-size: 1.2em;">Dec. 4</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">Dec. 1, 1966</span> 19 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Lloyd E. Saylor</span> M.D.				23B. DATE SIGNED <span style="font-size: 1.2em;">Dec 6, 1966</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Lloyd E. Saylor</span>	
23D. ADDRESS <span style="font-size: 1.2em;">3902 Greenmount Ave. Baltimore, Md.</span>							
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12-8-66</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">All Saints Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Reisterstown, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 8 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. F. ...</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Christine E. Donovan</span>		25D. ADDRESS <span style="font-size: 1.2em;">3815 Roland Ave</span>	

2011 N. Harry Avenue

7-2-1963

Witness

Twelve miles

U.S.A.

Maryland

domestic

domestic

Elizabeth House

Marion Brown

Elizabeth V. Brown, 2011 N. Harry Avenue

to

Elizabeth

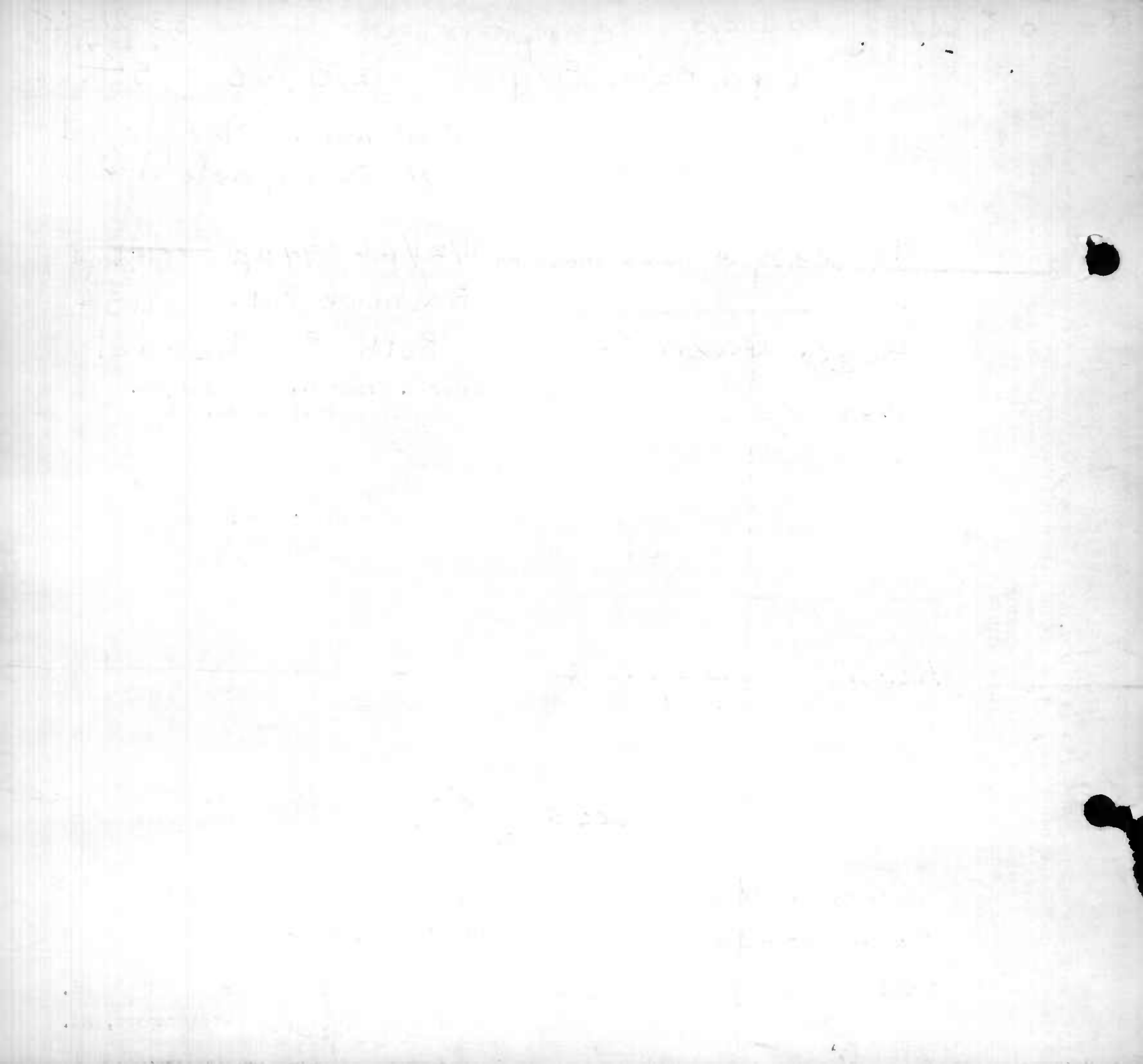
to the court  
in the case of  
Elizabeth V. Brown

Exhibit 12-8-66 All rights reserved  
Baltimore, Maryland

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>33-91-28</u>	
66-24714 66 12278				66 12278	
BIRTH NO.				CERTIFICATE OF DEATH	
MTC CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Green, Baby Boy</u>				<u>12/5/66</u> <u>5<sup>25</sup></u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>				A. STATE <u>Baltimore, Maryland</u>	
(If not in hospital or institution, give street address or location)				B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)	
<u>38</u>				<u>911 Bonaparte Ave</u>	
5. SEX <u>M</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>11/21/66</u>	9. AGE (In years lost birthday) <u>14 days</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>14 days</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Roger Green Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Ruth R. Michael</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Roger U. Green 911 Bonaparte Ave. Baltimore, Md</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Tracheo-esophageal fistula</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>Nov. 21</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>T-E fistula</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 21</u> <u>1966</u> to <u>Dec 5</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 5</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. H. Khazei</u>				23B. DATE SIGNED <u>Dec 5-1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. H. KHAZEI</u>				23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/7/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bloomington</u>	
24D. LOCATION <u>Bloomington</u>		(City, town, or county)		(State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Westernport, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12279		BALTIMORE CITY DEPARTMENT		Registered No. 66 12279	
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED (Type or Print) Daisy Elizabeth Campbell</div> <div>2. DATE AND HOUR OF DEATH December 6, 1966 2:30 P.M.</div> </div>					
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION 90 Wesley Home, Inc.</div> <div>(If not in hospital or institution, give street address or location)</div> </div> </div>			<div> <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div>A. STATE Maryland</div> <div>B. COUNTY Baltimore</div> <div>C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-15</div> <div>D. STREET ADDRESS (If rural, give location) 2211 West Rogers Avenue</div> </div>		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 2/19/1880	9. AGE (In years last birthday) 86	<div>If Under 1 Yr. Months Days</div> <div>If Under 24 Hrs. Hours Min.</div>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Kenneth Campbell			14. MOTHER'S MAIDEN NAME Elizabeth Balster		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-1835	17. INFORMANT The Wesley Home, Inc. 2211 W. Rogers Ave.		ADDRESS
<div>18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</div> <div>CAUSE OF DEATH</div> <div>(A) Abdominal carcinomatosis -</div> <div>(B) primary undetermined</div> <div>(C)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div>					
<div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<div>22. I certify that (I) (this hospital) attended the deceased from 26 December 19 65 to 6 December 19 66.</div> <div>that (I) (we) last saw the deceased alive on 30 November 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>					
23A. SIGNATURE John W. Barnaby				23B. DATE SIGNED 8 Dec 66	
23C. PHYSICIAN'S NAME (Type) JOHN W. BARNABY				23D. ADDRESS 1531 E North Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/1966		24C. NAME of CEMETERY or CREMATORY Oaklawn Cemetery	
24D. LOCATION Elkridge, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1966		25B. NAME OF REGISTRAR R. D. B. F. F. F.		25C. FUNERAL DIRECTOR Wm. J. Tidman & Sons north L.P.A.	

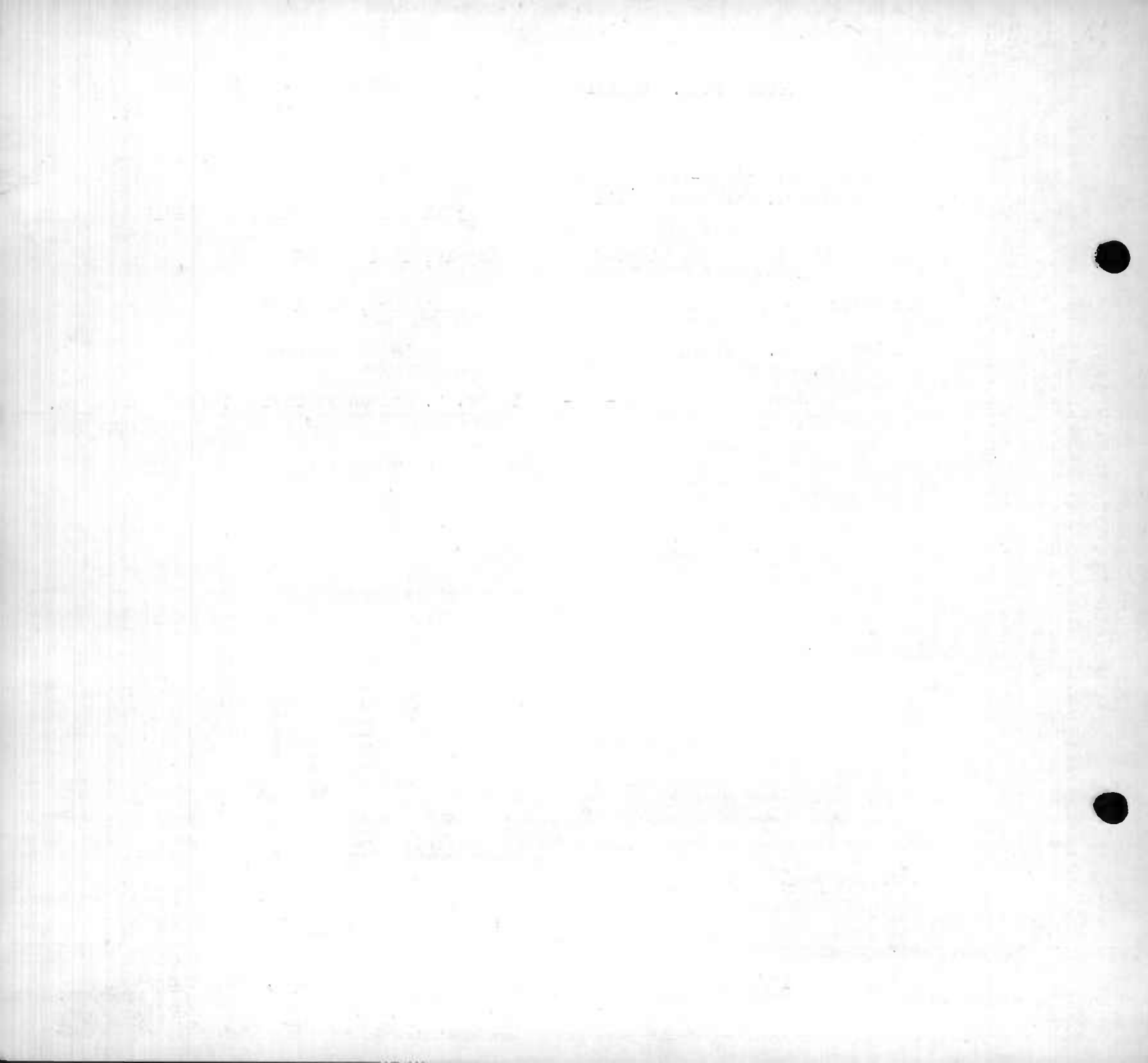




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 12280</span>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">66 12280</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Elizabeth C. Warfield</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">December 6, 1966</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">1711 East Thirty-third Street</span> <span style="font-size: 1.5em;">Baltimore, Maryland 21218</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">15-11</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3511 Calloway Avenue</span> <span style="font-size: 1.2em;">21215</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">May 18, 1881</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">85</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Homemaker</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">William H. Braun</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Katie Hardtner</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span> <span style="font-size: 1.2em;">None</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220-480-680 T</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. H. Nelson Warfield 7025 Plymouth Rd.</span>	
18. <span style="font-size: 1.5em;">782.71</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Cardiac Failure</span> DUE TO  (B) DUE TO  (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">October 6, 1966</span> to <span style="font-size: 1.2em;">December 6, 1966</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Dec. 6, 1966</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">George E. Shannon</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">Dec. 7, 1966</span>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <span style="font-size: 1.2em;">412 Medical Arts Building</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12/10/1966</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Woodlawn Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Woodlawn, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 8 1966</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. Folsom</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Wm. J. Fisher &amp; Sons</span>			



B-530

66 12281

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12281

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANN E. BENNETT

2. DATE AND HOUR PRONOUNCED DEAD

December 6, 1966

4:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

8136 Cornwall Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
married

8. DATE OF BIRTH

23 Nov 1924

9. AGE (In years  
last birthday)  
42If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S. Carolina

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Trall Price

14. MOTHER'S MAIDEN NAME

Annie Lloyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Dick L. Bennett, 8136 Cornwall Rd. 21222

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/7/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

23B. DATE

12-10-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 9 1966

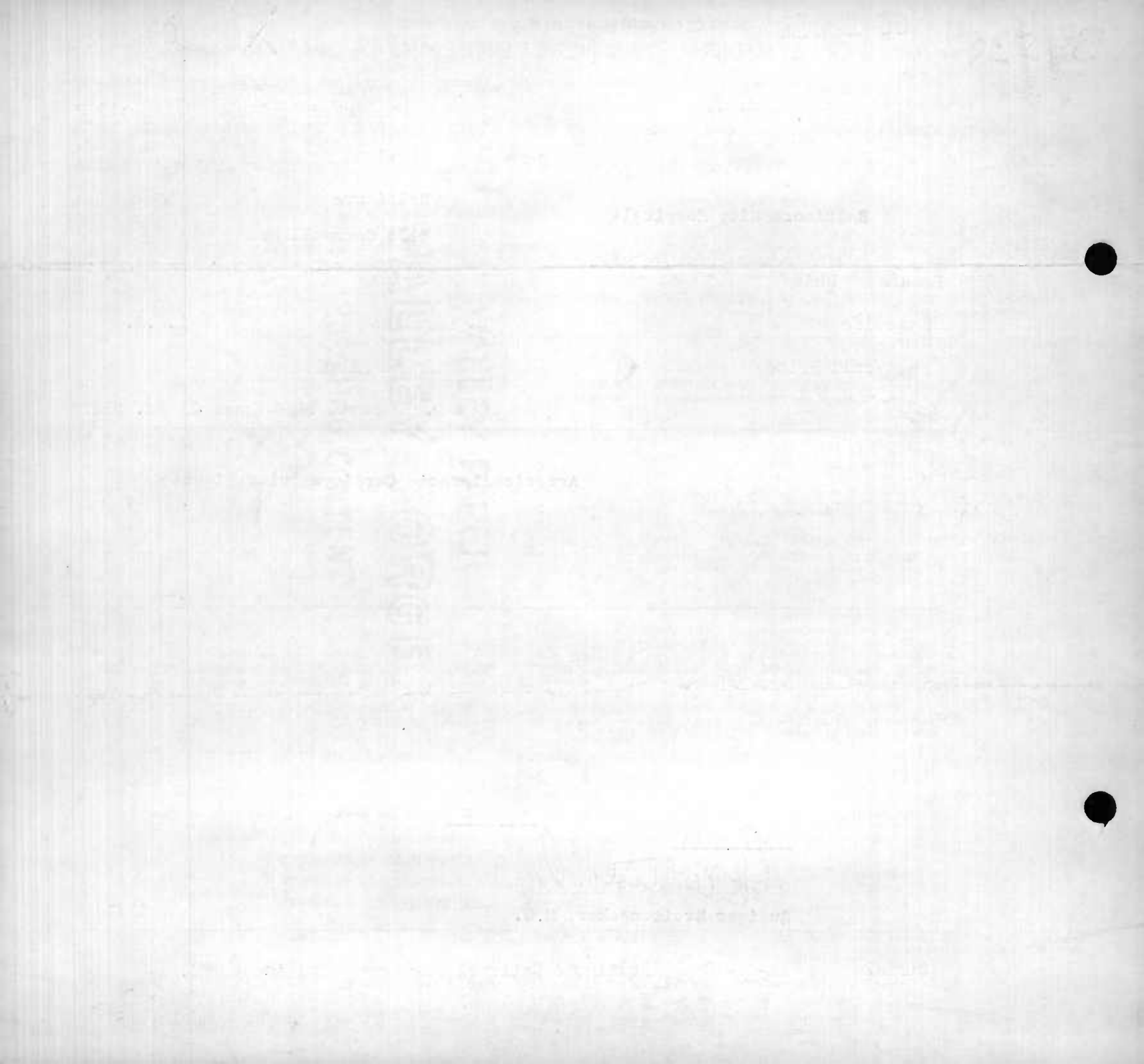
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

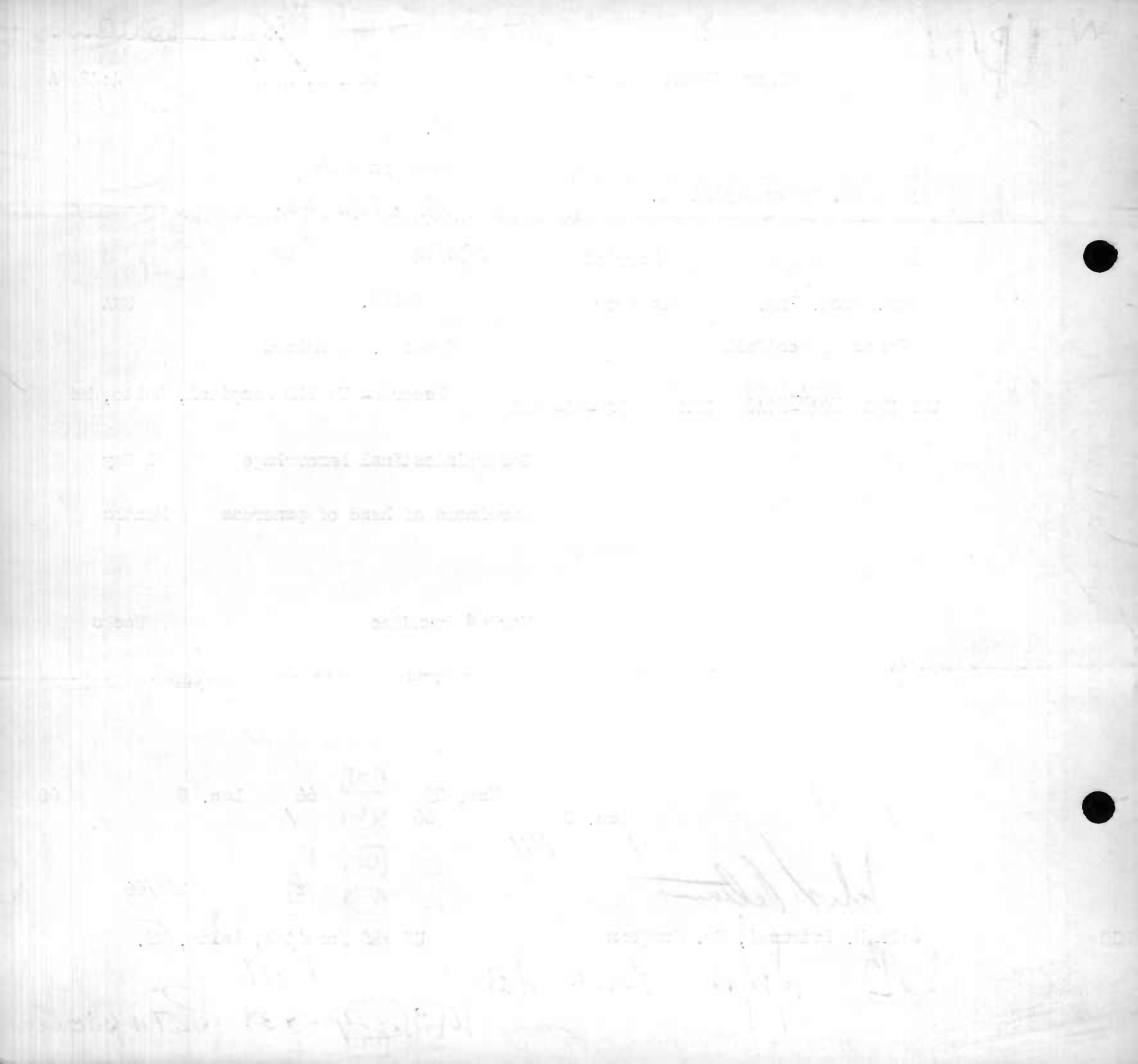
Ullrich Funeral Home, Dundalk, Md.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 12282</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">66 12282</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Elmer William Westfall</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Dec. 8, 1966</span> <span style="float: right;">4:42 A.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">US Public Health Service Hospital Wyman Pk. Drive &amp; 31st St.</span>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">9.9.C.</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Brooklyn Park</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">52-20 13 W. First Ave.</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">5/31/04</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">62</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">1st. Asst. Eng.</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Seafarer</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Calif.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">James W. Westfall</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Grace I. Blanchard</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) USN <span style="font-size: 1.2em;">YES</span> <span style="font-size: 1.2em;">1924-1928</span> <span style="font-size: 1.2em;">1940-1946</span> USN		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">347-01-1101</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Records- US PHS Hospital, Balto, Md</span>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Gastrointestinal hemorrhage</span>			INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 Day</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Carcinoma of head of pancreas</span>			Months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">Marked jaundice</span>			Weeks		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">yes</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">yes</span>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Nov. 25</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">Dec. 8</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Dec. 8</span> 19 <span style="font-size: 1.2em;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <span style="font-size: 1.2em;">12/8/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">John N. Petrucci Sr. Surgeon</span>		23D. ADDRESS <span style="font-size: 1.2em;">US PHS Hospital, Balto, Md.</span>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <span style="font-size: 1.2em;">12/12/66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Balt. Nat.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balt.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 9 1966</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Faldut</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">101 E. Carey - 137</span>		ADDRESS <span style="font-size: 1.2em;">Patapso Co.</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

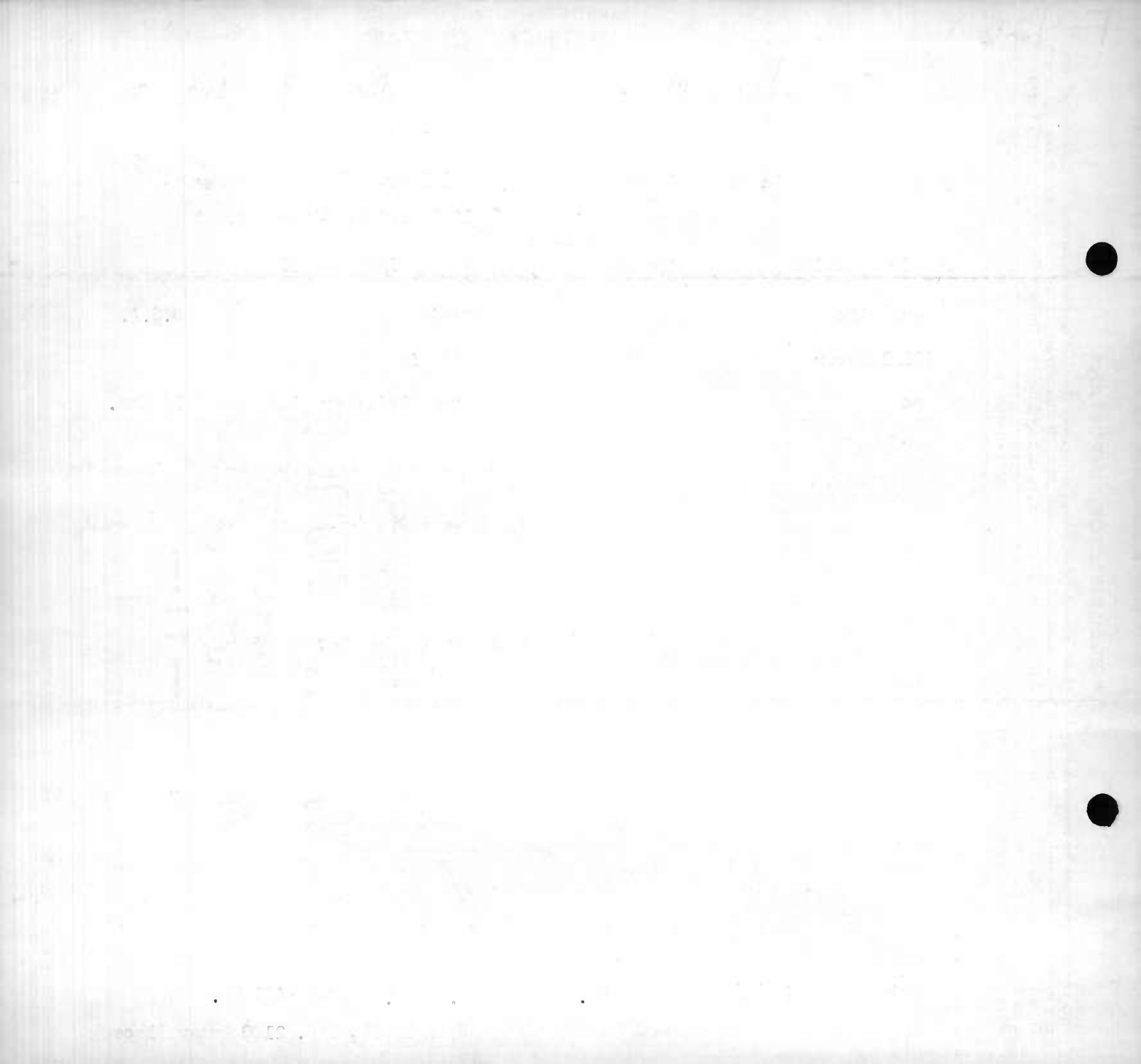
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12283	
66 12283					
CERTIFICATE OF DEATH					
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Harry N. McKenna			12-7-66 1:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
South Baltimore General Hosp.			Maryland		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			21-02		
Baltimore			21230		
D. STREET ADDRESS (If rural, give location)			1210 W. Cross St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M.	White	Married	8-14-1920	46	Labour
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Maryland			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Harry N. McKenna			Clara Rithman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
Yes WW II			212 076784		
17. INFORMANT			ADDRESS		
Genevieve McKenna			Same		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) DUE TO		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Hepatic Coma		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			! Bleeding Varices		
II			(C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Cirrhosis of liver 5 years		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
0			Planned resection due to		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				No	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (if this hospital) attended the deceased from 11-28 19 66 to 12-7 19 66, that (we) last saw the deceased alive on 12-7 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Rifat Abouey				12-7-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Rifat Al-Ahousy				1213 light St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/10/66		London Park	
24D. LOCATION (City, town, or county)		24E. STATE		24F. COUNTRY	
Baltimore		Md		USA	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 9 1966		Robert E. Finken		John J. Cowan	
				Baltimore Md	

1891  
The [illegible] [illegible]  
[illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible]



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12284</u>	
BIRTH NO. <u>66 12284</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Fleischer Molly</u>		2. DATE AND HOUR OF DEATH <u>Dec. 7 1966</u> <u>6</u> <sup>10</sup> <u>p</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Levinale, Hebrew Home and Infirmary</u> <u>91</u>		D. STREET ADDRESS (If rural, give location) <u>1722 East Baltimore Street</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>1876</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Hillel Beber</u>		14. MOTHER'S MAIDEN NAME <u>Lillie</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harry Fleischer</u> ADDRESS <u>3406 Oakfield Ave.</u>	
18. <u>466X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>pulmonary emboli prot.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>phlebothrombosis of leg</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>1 week</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD and congestive failure</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 24</u> 19 <u>60</u> to <u>Dec. 7</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ruth Willmer</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Dec. 7, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ruth Willmer</u>		23D. ADDRESS <u>Levinale, Hebrew Home and Infirmary</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/8/66</u>		24C. NAME of CEMETERY or CREMATORY <u>HEBREW MT? CARMEL CEM. CORP.</u>	
24D. LOCATION (City, town, or county) (State) <u>German Hall Rd.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>JACK LEWIS, INC.</u> ADDRESS <u>2100 Eutaw Place</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>66 12285</b>		<b>CERTIFICATE OF DEATH</b>		66 12285	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Matilda Steinmetz</b>			2. DATE AND HOUR OF DEATH <b>Dec. 6th - 1966 9.40 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital</b>			A. STATE B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 26-09</b>		
D. STREET ADDRESS (If rural, give location) <b>703 S. Dean St.</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-5-01</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>
13. FATHER'S NAME <b>Frederick W. Konigkramer</b>			14. MOTHER'S MAIDEN NAME <b>Katie Bowers</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>George F. Steinmetz</b>		ADDRESS <b>Same</b>
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Asb. Cerebrovascular Accident</b>		CAUSE OF DEATH (A) DUE TO <b>Anteroinferior Cerebrovascular Disease</b> (B) DUE TO <b>Sickle Cell Anemia</b> (C) <b>Sickle Cell Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct-10th</b> 19 <b>66</b> to <b>Dec-6th</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 6th</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Nahum</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>Albert Nahum</b>			23D. ADDRESS <b>Church Home &amp; Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-9-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>	
24D. LOCATION <b>Md.</b>		24E. NAME OF CEMETERY or CREMATORY		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Thelma A. Hoffmann</b>	
				ADDRESS <b>3218 W. Hudson St.</b>	

Martha Steinmetz

Church House Hospital

Female White Married

Housewife

Frederick W. Konigsmeyer Katie Bowers

George F. Steinmetz

For Gastroenteric Disease

(Intestinal Endometritis)

Richard Muller

Mr

Oct-10 to Oct-14

Albert Nathan

Church House Hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

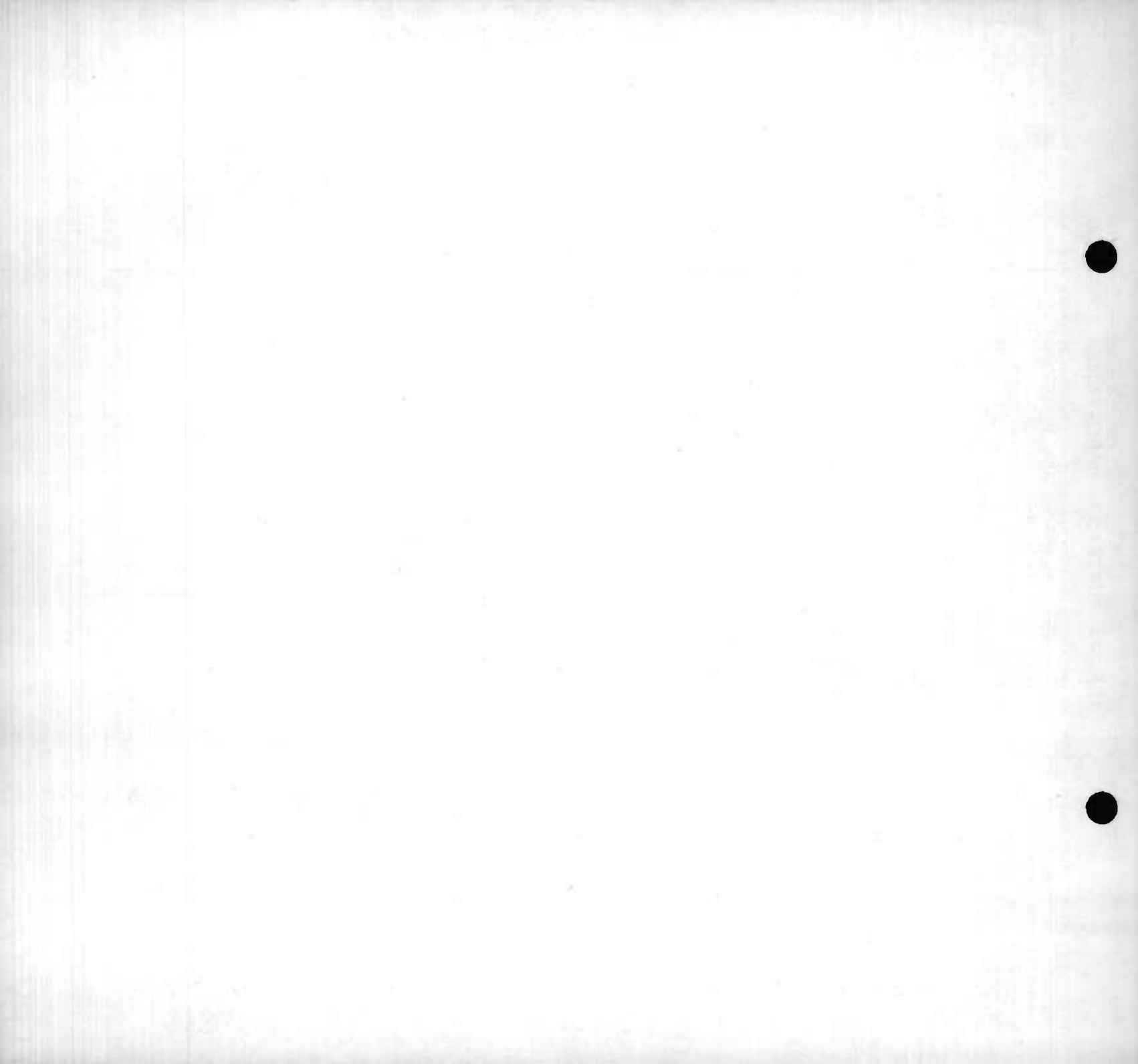
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12286</u>	
BIRTH NO. <u>66 12286</u>		<b>CERTIFICATE OF DEATH</b>		Registered No. <u>66 12286</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Dorothy M. V. Enzenga</u>		2. DATE AND HOUR OF DEATH <u>Dec. 8, 1966</u>   <u>1:10</u> <u>A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Balto. Gen. Hospital</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>1710 S. Charles St.</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>March 2, 1916</u>	9. AGE (In years lost birthday) <u>50</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Kearney Nalls</u>		14. MOTHER'S MAIDEN NAME <u>Roxy Pettit</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Roslie Gray</u>	
ADDRESS <u>Burnie Md.</u>		ADDRESS <u>412 Kent Circle Glen</u>			
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <u><del>Acute Myocardial Infarction</del></u> DUE TO <u>A - Acute Subacute Heart Disease</u> DUE TO <u>H - Pulmonary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1949</u> to <u>Dec. 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. P. Friedman</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/8/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. P. FRIEDMAN</u>		23D. ADDRESS M.D. <u>1319 Lyster St. - Baltimore Md. 21230</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12 10 66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cathedral</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1966</u>		24F. NAME OF REGISTRAR <u>Robert E. Fickens</u>	
24G. FUNERAL DIRECTOR <u>Mc Cully</u>		24H. ADDRESS <u>130 E. Fort Ave.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12287</u>	
BIRTH NO. <u>66 12287</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type at Print) <u>BABY BOY "B" McCLENON</u>		2. DATE AND HOUR OF DEATH <u>12-8-66</u> <u>12.10 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		A. STATE <u>MARYLAND</u> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>126 NORTH CHAPEL STREET</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>12-7-66</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>BRENDA McCLENON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>PREMATURITY</u> <u>MULTIPLE PREGNANCY</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/7/66 7:50 PM</u> to <u>12/8/66 12:00 AM</u> that (I) (we) last saw the deceased alive on <u>12/8/66 12:00 AM</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Elizabeth Maxwell, M.D.</u>				23B. DATE SIGNED <u>12/8/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>ELIZABETH MAXWELL</u>		23D. ADDRESS M.D. <u>JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>12/8/66</u>		24C. NAME of CEMETERY or CREMATORY <u>The Johns Hopkins Hosp.</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u>	

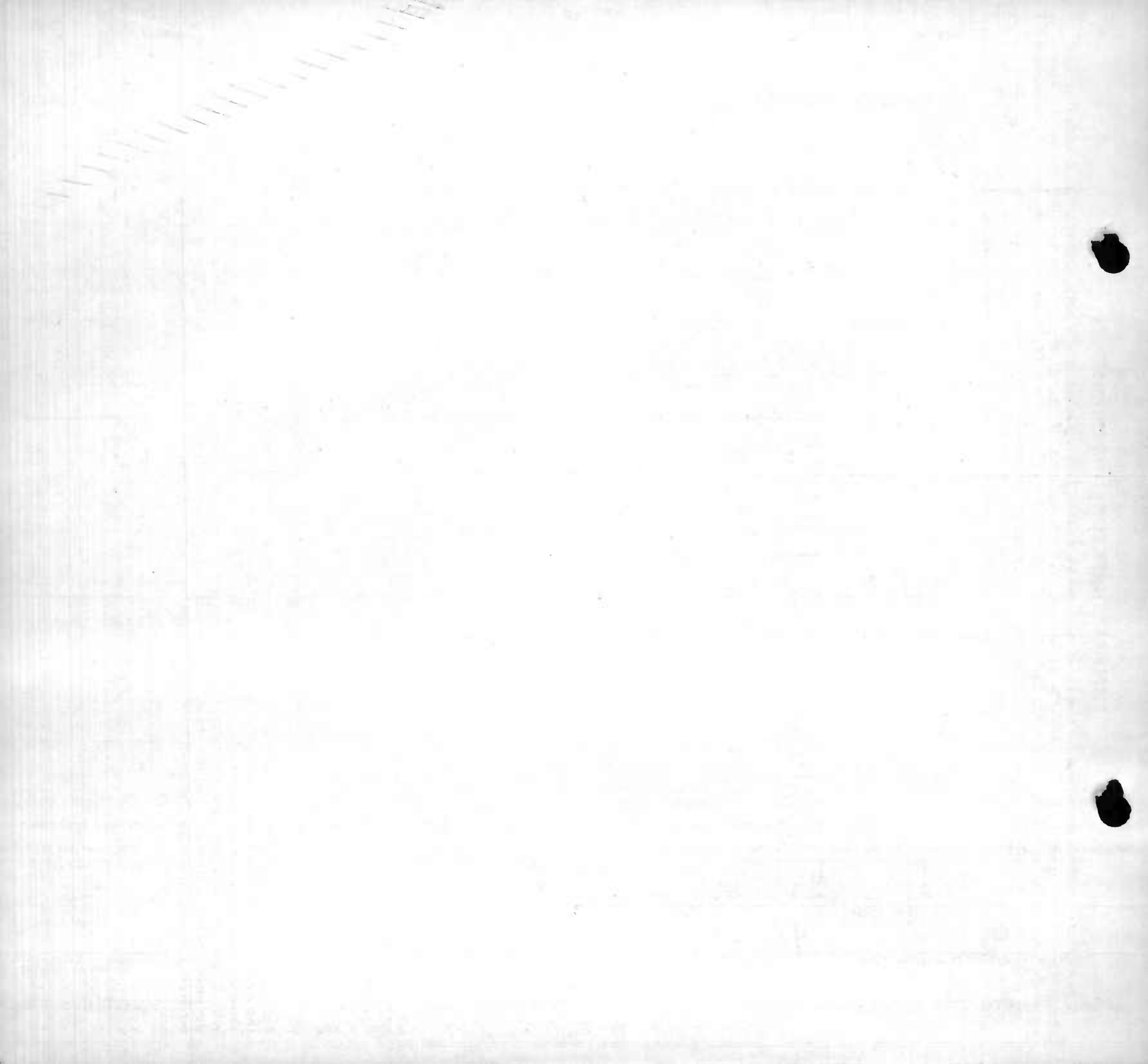




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 12288</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12288</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>William Chaffman</b>		2. DATE AND HOUR OF DEATH <b>12-7-66 12:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-05</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #21225</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hosp</b>		D. STREET ADDRESS (If rural, give location) <b>1105 Edwight Court</b>		E. DATE OF BIRTH <b>4-22-1889</b>	
5. SEX <b>M</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <b>77</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Benjamin</b>	
14. MOTHER'S MAIDEN NAME <b>Gail</b>		15. Was deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Family</b>		ADDRESS <b>Same</b>		18. CAUSE OF DEATH <b>Massive Pleural Effusion ? Flare up of old TB</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>003.1/260X</b>		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes</b>		21. WOUND <b>infection after Prostrectomy</b>		22. YEN	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>10-26 1966</b> to <b>12-7 1966</b> , that (we) last saw the deceased alive on <b>12-7 1966</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Rafat Abouy</b>		23B. DATE SIGNED <b>12-7-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Rafat Al-Abouy</b>		23D. ADDRESS <b>1213 Light St.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>3</b>	
24B. DATE <b>12/10/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>London G.K.</b>		24D. LOCATION (City, town, or County) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fabela</b>		25C. FUNERAL DIRECTOR <b>M. G. G. 237</b>	
25D. ADDRESS <b>Pasadena</b>		DEC 9 1966			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12289</u>	
BIRTH NO. <u>66 12289</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>FREDERICK (FRED) OTRADOVEC</u>		2. DATE AND HOUR OF DEATH <u>Dec. 8, 1966</u>   <u>8 a.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>33 Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>21205</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>717 N. Collington Ave.</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>3/29/04</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret-self-employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Esso Station</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>James Otradovec</u>			14. MOTHER'S MAIDEN NAME <u>Mary Keiser</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>16-32-7696</u>		16. SOCIAL SECURITY NO. <u>216-32-7696</u>		17. INFORMANT <u>Ruth Schluttanhafer, Otradovec, wife</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Acute Coronary Thrombosis</u> DUE TO (B) <u>Coronary Arteriosclerosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>5 years +</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>10</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 1963</u> to <u>December 1966</u> , that (I) (we) last saw the deceased alive on <u>November 15, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Vernon H. Norwood</u> M.D.				23B. DATE SIGNED <u>December 8, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Vernon H. Norwood</u>		23D. ADDRESS M.D. <u>Church Home Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/12/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc</u> <u>3331 Brehms Lane</u>	

Correct forward the above 30 in the  
Germany contribution 2/20/20

✓

Received from  
Germany 2/20/20

Dr. J. H. Johnson

2/20/20  
2/20/20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12290</span>	
BIRTH NO. <span style="float: right;">66 12290</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <span style="float: right;">Thomas</span>		2. DATE AND HOUR OF DEATH	
(Type or Print) <span style="float: right;">Vincen T Talbert</span>				12/8/66 7 <sup>15</sup> am <span style="float: right;">A M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 2em;">33</span>  The Johns Hopkins Hospital				A. STATE <span style="font-size: 1.5em;">Maryland</span>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">Baltimore</span>	
				D. STREET ADDRESS (If rural, give location) <span style="float: right;">27-05</span> <span style="font-size: 1.5em;">6635 Walther Avenue</span>	
5. SEX <span style="font-size: 1.5em;">Male</span>	6. RACE <span style="font-size: 1.5em;">White</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.5em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.5em;">11/2/98</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">68</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Chief Technician</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">Johns Hopkins Med. School</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Balto. Md.</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">Harry Talbert</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Mary Drane</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">220-30-4217</span>		17. INFORMANT <span style="font-size: 1.5em;">21093</span> ADDRESS <span style="float: right;">Rd.</span> <span style="font-size: 1.5em;">Eleanor Williams, dght. 2526 Londonderry</span>	
18. <span style="font-size: 2em;">443X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.5em;">Cardiac arrest</span> DUE TO (B) <span style="font-size: 1.5em;">ASUD, #</span> DUE TO (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.5em;">hypertension</span>				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <span style="font-size: 1.5em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <span style="font-size: 1.5em;">12/7</span> 19 <span style="font-size: 1.5em;">66</span> to <span style="font-size: 1.5em;">12/8</span> 19 <span style="font-size: 1.5em;">66</span> , that <del>the</del> (we) last saw the deceased alive on <span style="font-size: 1.5em;">12/7</span> 19 <span style="font-size: 1.5em;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Monica M Buckley</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">12/8</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Monica M Buckley</span>		23D. ADDRESS <span style="font-size: 1.5em;">Johns Hopkins Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>	24B. DATE <span style="font-size: 1.5em;">12/12/66</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.5em;">Parkwood Cemetery</span>		24D. LOCATION (City, town or county) (State) <span style="font-size: 1.5em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">DEC 9 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Talbert</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Schimunek Funeral Home, Inc. 3331 Brehms Lane</span>	



H-400  
17-452

66 12291

BALTIMORE CITY HEALTH DEPARTMENT

66 12291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

(ALSO KNOWN AS HOLEWINSKI)

2. DATE AND HOUR PRONOUNCED DEAD

FRANK

C.

HOLEW

December 7, 1966

7:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6319 Belair Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
single

8. DATE OF BIRTH

2/23/1901

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

ret-office clerk

10B. KIND OF BUSINESS OR INDUSTRY

U.S.F. & G.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Stanley Holewinski

14. MOTHER'S MAIDEN NAME

Catherine Ratajczak

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

218-12-3215A

17. INFORMANT

ADDRESS

Jesse Holew, brother, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cardiac Tamponade  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Rupture of Aneurysm of Aorta.  
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK

NOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/12/66

23C. NAME of CEMETERY or CREMATORY

St. Stanislaus Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 9

1966

24B. NAME OF REGISTRAR

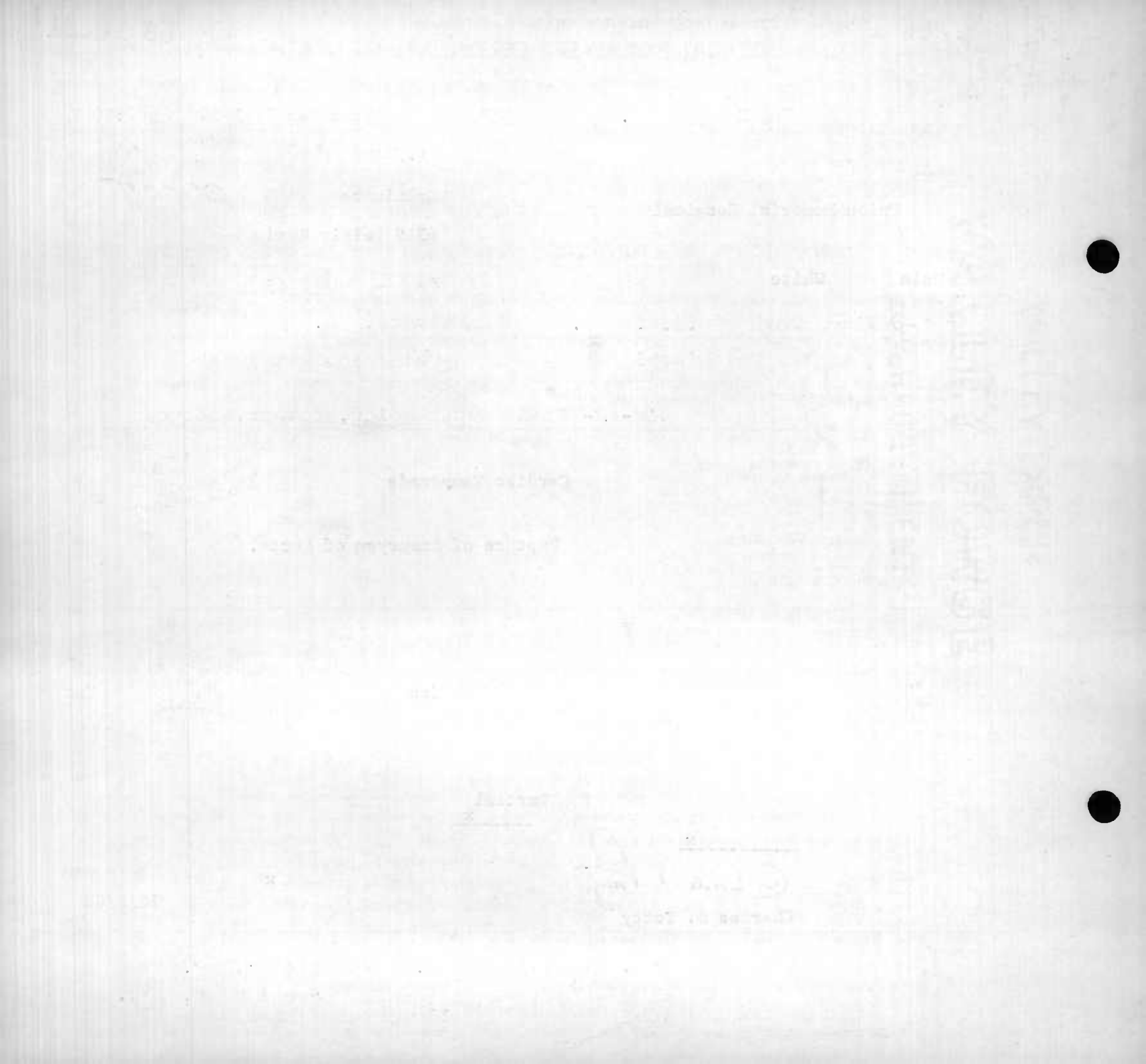
Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane

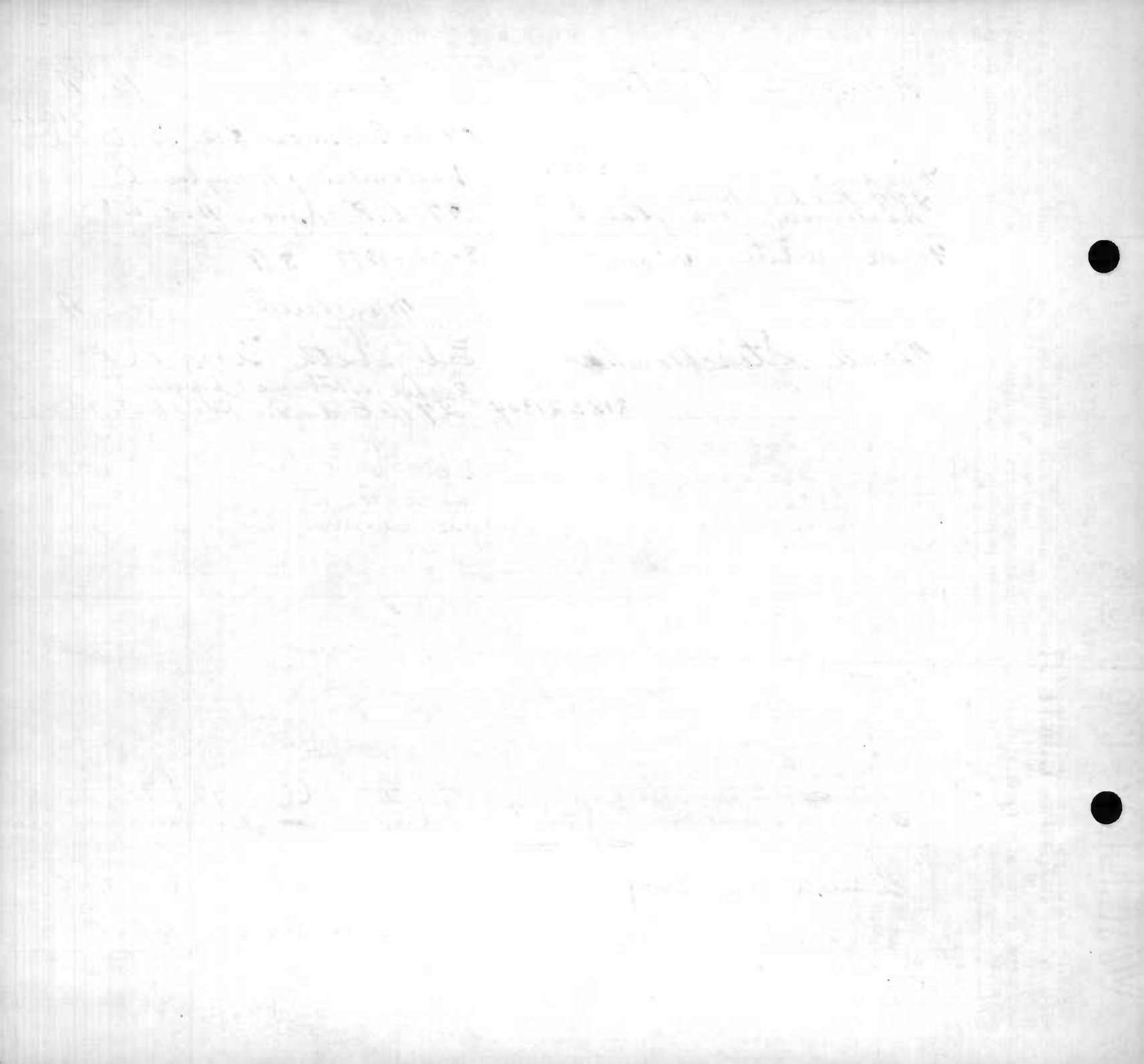




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. _____	
BIRTH NO. 66 12292				66 12292	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Alice S. Tipton</i>				2. DATE AND HOUR OF DEATH <i>December 8, 1966 12:10 A</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Margland General Hospital</i> <i>8207 Dundee Ave.</i> <i>Baltimore, Maryland</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Maryland</i>	
D. STREET ADDRESS (If rural, give location) <i>2716 Erdman Ave</i>				E. ZIP CODE <i>21214</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>3-29-1977</i>	9. AGE (In years last birthday) <i>89</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Noah Stinchcomb</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Zinger</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>218521344</i>		
17. INFORMANT <i>Rachel Watkins (Daughter)</i>			ADDRESS <i>2716 Erdman Ave - Balto. 14, Md</i>		
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebro-Vascular Accident</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>middle cerebral art.</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>12/7/66</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>Dr</i> (this hospital) attended the deceased from <i>12/3</i> 19 <i>66</i> to <i>12/7</i> 19 <i>66</i> , that <i>Dr</i> (we) last saw the deceased alive on <i>12/7</i> 19 <i>66</i> and that <i>Dr</i> (our) apian death occurred on the date and hour and from the causes stated above. (I) <i>Dr</i> (did) <i>not</i> view the body after death.					
23A. SIGNATURE <i>Bernard du Buy</i>				23B. DATE SIGNED <i>12/7/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Bernard du Buy</i>				23D. ADDRESS <i>Maryland Genl. Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/10/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cokesbury Memorial Cemetery</i>	
24D. LOCATION <i>Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 9 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Schumaker Funeral Home, Inc.</i>			
25D. ADDRESS <i>3331 Brehms Lane #13</i>					



66 12293

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12293

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SOPHIA MARIE RADER

2. DATE AND HOUR PRONOUNCED DEAD

December 7, 1966 2:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1101 N. Luzerne Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
widowed

8. DATE OF BIRTH

4/27/79

9. AGE (in years  
last birthday)

87

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Novak

14. MOTHER'S MAIDEN NAME

Anna Kadan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216-10-6304

17. INFORMANT ADDRESS

5304 A. Goodnow Rd., 6  
Josephine Novak, neice,

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/7/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/10/66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION (City, town, or county) (State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 9 1966

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
2601 E. Madison St.

ADDRESS

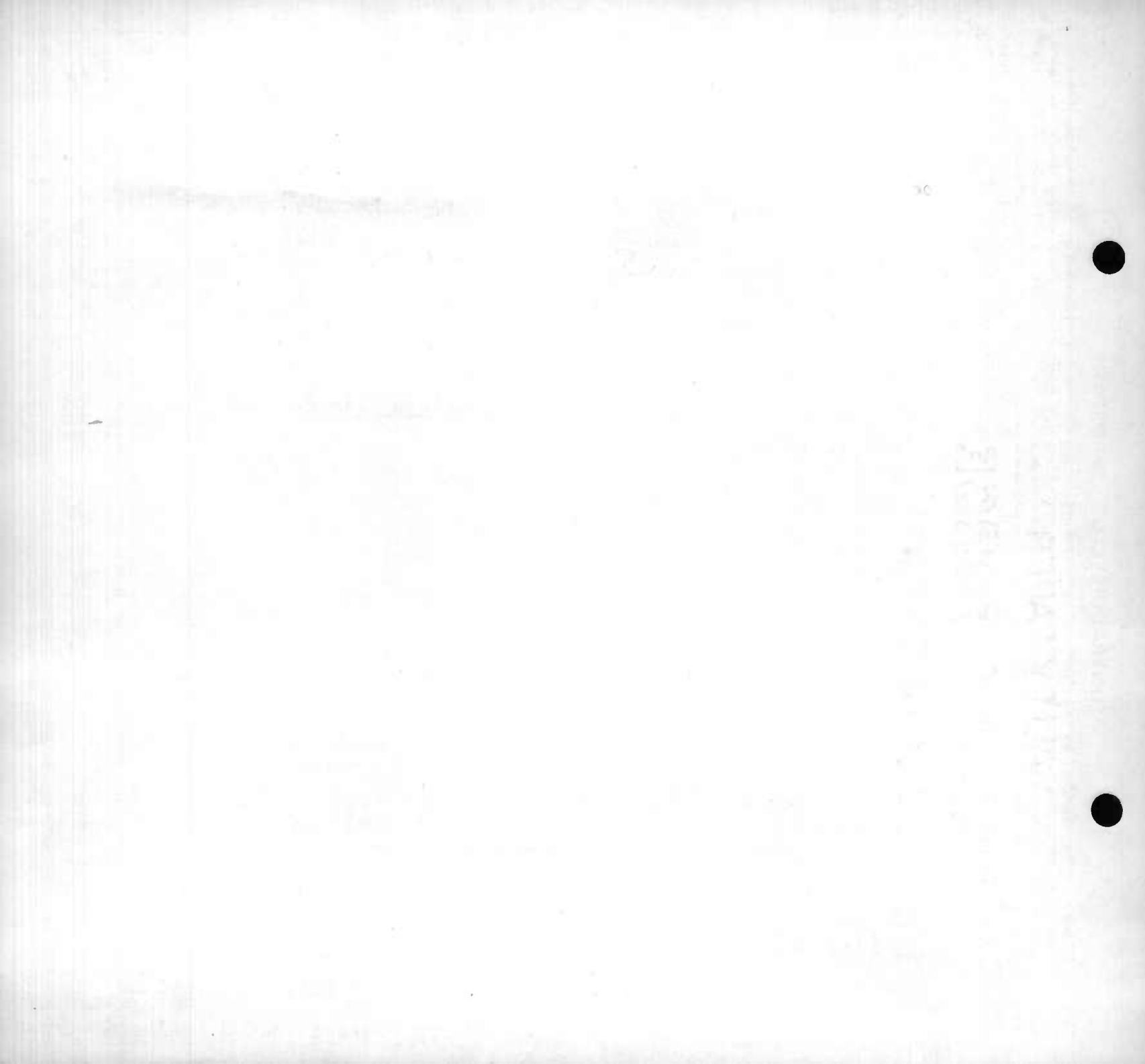
WALLEY & RIGGIE

W. A. RIGGIE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12294	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 66 12294</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>NANCY SMALLWOOD</u>			2. DATE AND HOUR OF DEATH <u>5:30 PM 12/7/66 M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University Hospital</u> <u>Baltimore, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>1304</u> D. STREET ADDRESS (If rural, give location) <u>2917 Parkwood Avenue</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>10/2/47</u>	9. AGE (in years last birthday) <u>19</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>ROBERT SMALLWOOD</u>			14. MOTHER'S MAIDEN NAME <u>FANNIE TUTMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Fannie Smallwood 2917 Parkwood Avenue</u>		
18. <u>576X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>GRAM NEGATIVE SEPTICEMIA</u> DUE TO (B) <u>BRITONIDS</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/5/66</u> to <u>12/7/66</u> , that (I) (we) last saw the deceased alive on <u>12/7/66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert E. Johnson</u>				23B. DATE SIGNED <u>12/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. ANN ROBINSON</u>				23D. ADDRESS <u>WH</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-12-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George Kelson 1348 N. Calhoun Street</u>	



1  
T-413

66 12295

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12295

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GOLDY

TALBOTT

2. DATE AND HOUR PRONOUNCED DEAD

December 7, 1966

6:21 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5346 Wright Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 8, 1904

9. AGE (in years last birthday)

62

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Registered Nurse

10B. KIND OF BUSINESS OR INDUSTRY

Hospitals

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Wesley Hough

14. MOTHER'S MAIDEN NAME

Mary Virginia Barrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

218-22-6376

17. INFORMANT

ADDRESS

Dewey F. Talbott 5346 Wright Ave. Balto. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Barbiturate Intoxication.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

5346 Wright Avenue

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 12 7 '66 P

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Overdose of barbiturates.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/8/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12-10-66

23C. NAME of CEMETERY or CREMATORY

Mt. Olivet Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore City, Maryland

24A. DATE REC'D BY HEALTH DEPT.

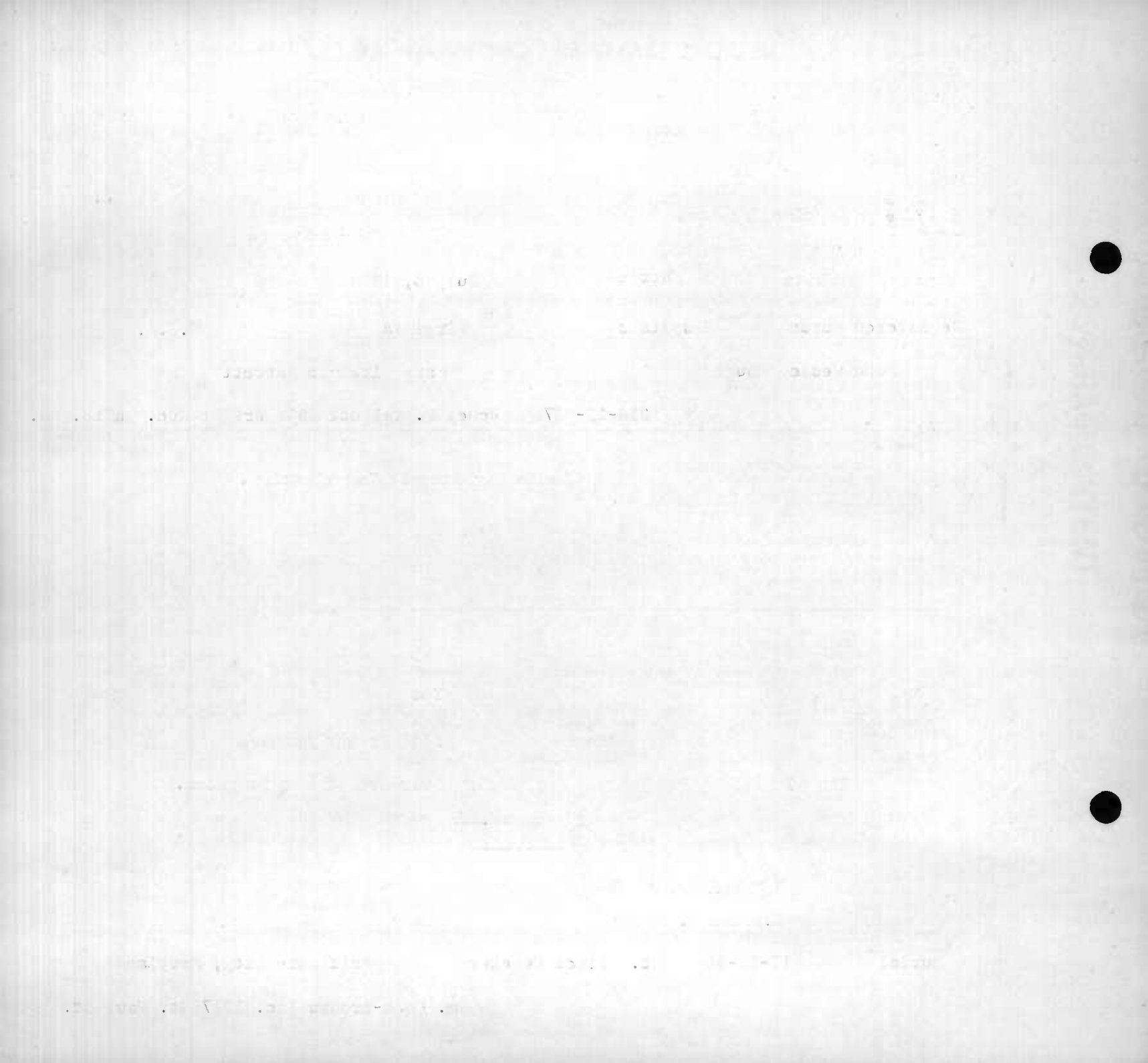
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Inc. 1217 St. Paul St.

DEC 9 1966





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <span style="float: right;">66 12296</span>					
BIRTH NO. <span style="font-size: 1.5em;">66 12296</span>										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">RICHIE, ELIZABETH R.</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">7 Dec 66 120 P.M.</span>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">UNIVERSITY OF MARYLAND Hosp</span>					A. STATE <span style="font-size: 1.2em;">MO</span> B. COUNTY <span style="font-size: 1.2em;">USA</span>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTO</span>					
					D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2722 Maryland Ave</span>					
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">DIVORCED</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">12-18-98</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">67</span>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Secretary</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Unknown</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md.</span>			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">Clinton Thomas Ross</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Coa Kimmel</span>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>				16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">Unknown</span>		17. INFORMANT <span style="font-size: 1.2em;">Mr. Clarence A. Kimmel</span>				
				ADDRESS <span style="font-size: 1.2em;">Sparta N. Jersey 100 E. Shore Trail</span>						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH <span style="font-size: 1.2em;">Lung Cancer</span>					
					INTERVAL BETWEEN ONSET AND DEATH					
					<span style="font-size: 1.2em;">CARCINOMA of Colon (not Histologic Dx)</span>					
					<span style="font-size: 1.2em;">PERITONEAL Abscess</span>					
					<span style="font-size: 1.2em;">Post Op Wound Infection</span>					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <span style="font-size: 1.2em;">11-20-66</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Obs. of Colon</span>			20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from <span style="font-size: 1.2em;">11-4</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">12-7</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) last saw the deceased alive on <span style="font-size: 1.2em;">12-7</span> 19 <span style="font-size: 1.2em;">66</span> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE <span style="font-size: 1.2em;">Michael B. Flynn</span>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <span style="font-size: 1.2em;">7 Dec 66</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MICHAEL B. FLYNN</span>					23D. ADDRESS <span style="font-size: 1.2em;">Haw Hosp</span>					
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12/10/66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Christ Episcopal Church Cem. Cambridge, Md.</span>			24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 9 1966</span>			25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fairbank</span>			25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Wm. Cook-Brooks F.H. 1217 St. Paul St.</span>			ADDRESS <span style="font-size: 1.2em;">Balto. Md. 21202</span>	

University of Maryland  
Biology

Clinton Thomas

5155 Maryland Ave  
12-18-28

Core Kimmel

George Bunt  
Residence of (clouded yellow)

Box 4 Colon

Michael B. Ryan

12-18-28

66 12297

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12297

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Rosie B. Johnson

2. DATE AND HOUR PRONOUNCED DEAD

11/25/66 3:10 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2737 North Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

?

8. DATE OF BIRTH

?

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Whitehead 3411 Forest Park Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Fatty alteration of liver

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/26/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/9/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetry

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 9 1966

Robert E. Fackema

Adolphus Halstead 1206 W North Ave

Unemployed

New England Salt Works

WALTON

W. S. R.

12/10/00 The Company

Adolphus Halstead 1200 N. Main

66 12298

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12298

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES H. HOLLAND

2. DATE AND HOUR PRONOUNCED DEAD

12-6-66

6:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

48 MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

210 W. Read Street 21201

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8/13/24

9. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Henry Holland

14. MOTHER'S MAIDEN NAME

Roasie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW 2

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Madaline Holland 210 W Read St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebral injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Epilepsy (by history)

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Read and Howard Sts.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 25 66 3:50a.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

fell on street

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/12/66

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 9 1966

Adolphus Halstead

Adolphus Halstead 1206 W North Ave

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

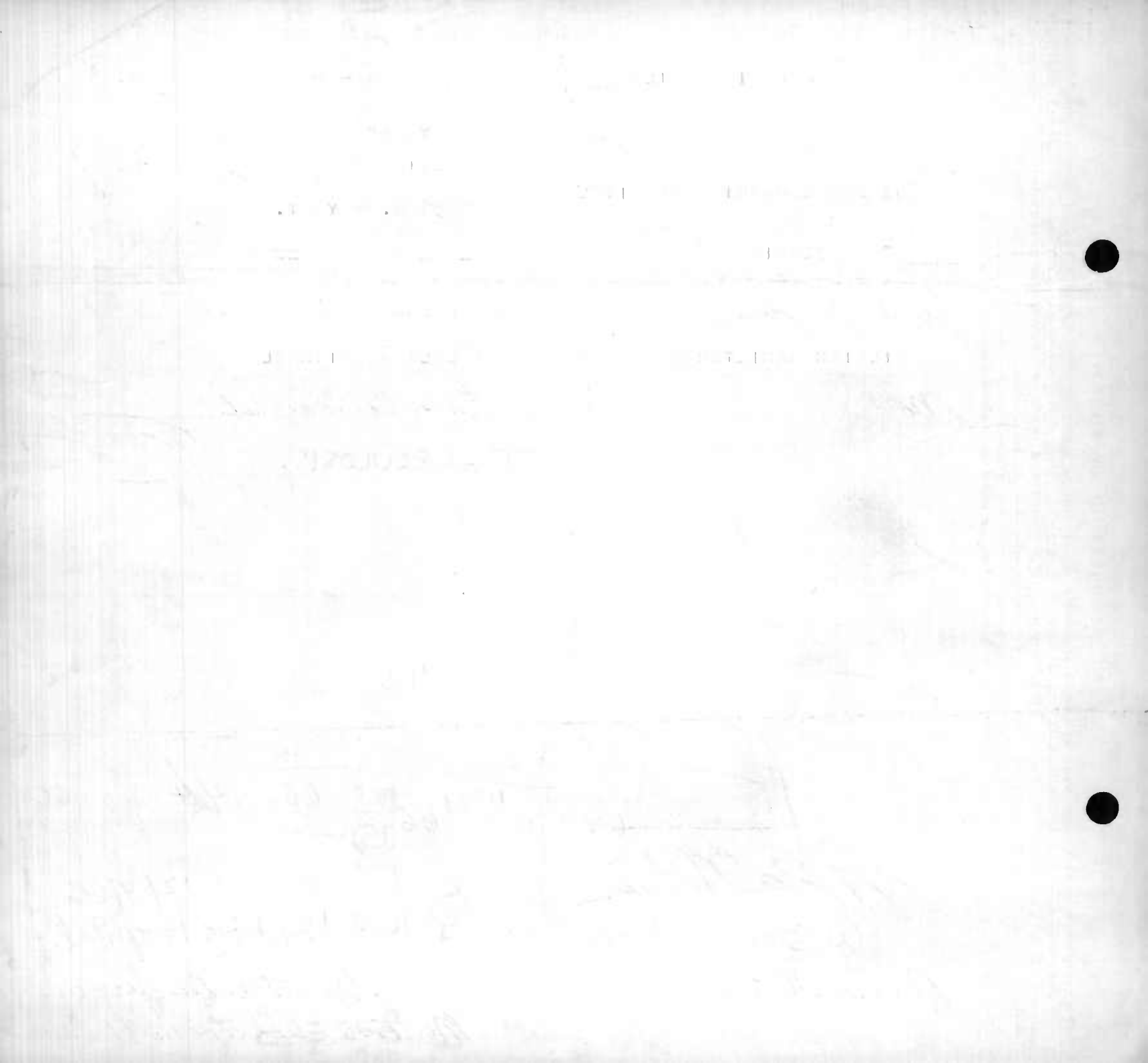
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12299				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12299	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHNNIE HAMILTON</b>				2. DATE AND HOUR OF DEATH <b>12-4-66</b> <b>1:55 P</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1431 N. GAY ST.</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SEPARATED</b>	8. DATE OF BIRTH <b>4-10-16</b>	9. AGE (In years lost birthday) <b>50</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Millon S. Caroline</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>WILLIAM HAMILTON</b>			14. MOTHER'S MAIDEN NAME <b>LULA CARMICHAEL</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lula Carmichael</b>		
18. <b>0087 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>TUBERCULOSIS.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/21/66</b> to <b>12/4/66</b> and that (I) (we) last saw the deceased alive on <b>12/4/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>W Stan Wilson</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>W Stan Wilson</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal Dec 7/66</b>		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Trenton New Jersey</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Milton E. Elckern</b>			

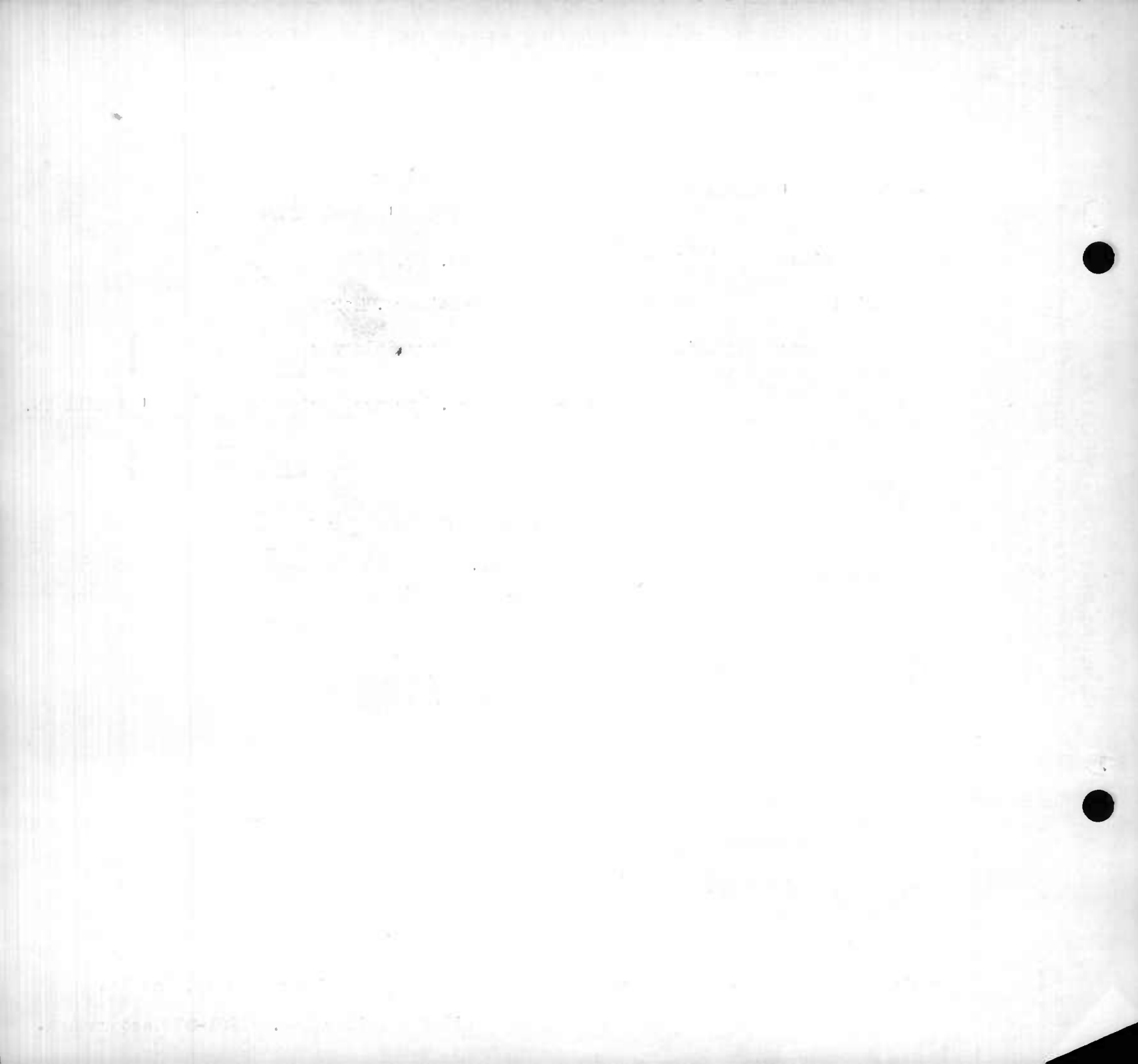




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12300</span>	
BIRTH NO. <span style="float: right;">66 12300</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="float: right;">ELIZABETH CLAYTOR</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">December 6, 1966</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <span style="float: right;">Maryland</span>			
<span style="font-size: 2em;">00</span> 2901 O'Donnell Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">Baltimore</span>			
		D. STREET ADDRESS (If rural, give location) <span style="float: right;">2901 O'Donnell Street</span>			
5. SEX <span style="float: right;">Female</span>	6. RACE <span style="float: right;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="float: right;">Widow</span>	8. DATE OF BIRTH <span style="float: right;">Oct. 29, 1894</span>	9. AGE (In years last birthday) <span style="float: right;">72</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Own Home</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Baltimore, Maryland</span>	
13. FATHER'S NAME <span style="float: right;">Henry Fegelein</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Mary Selmeyer</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">No</span>		16. SOCIAL SECURITY NO. <span style="float: right;">214-01-8785</span>		17. INFORMANT <span style="float: right;">Mrs. Margaret Friedline</span>	
				ADDRESS <span style="float: right;">2901 O'Donnell St.</span>	
18. <span style="font-size: 2em;">260X I</span>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <span style="font-size: 1.5em;">Pneumonia</span>		<span style="font-size: 1.5em;">72 hrs.</span>	
ANTECEDENT CAUSES		(B) <span style="font-size: 1.5em;">arteriosclerotic C.V.D.</span>		<span style="font-size: 1.5em;">10 yrs.</span>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <span style="font-size: 1.5em;">Diabetes Mellitus</span>		<span style="font-size: 1.5em;">15 yrs.</span>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 2em;">no</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.5em;">Jan 15</span> 1951 to <span style="font-size: 1.5em;">12/6</span> 1966, that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.5em;">Dec 4</span> 1966 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Isadore K. Grossman</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.5em;">12/9/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Isadore Karl Grossman</span>		23D. ADDRESS <span style="font-size: 1.5em;">1527 E. North Ave</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">12-10-1966</span>		24C. NAME of CEMETERY or CREMATORY <span style="float: right;">Sacred Heart</span>	
				24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore County, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 2em;">DEC 9 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Faldutsky</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="float: right;">Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 12301		CERTIFICATE OF DEATH		66 12301	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ANNA BELLE Spickman		12/7/66 1 12 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen Hosp.		A. STATE B. COUNTY Md. Harford			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	
8. DATE OF BIRTH 2/10/95		9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Mask Assembler	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Elijah Montgomery	
14. MOTHER'S MAIDEN NAME Annette Sarah		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-20-7161	
17. INFORMANT Edward O. Skillman		ADDRESS 422 Old Phila. Rd. Joppa, Md.			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Central thrombosis		2 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/7 1966 to 12/7 1966, that (I) (we) lost saw the deceased alive on 12/7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel C. Wilkerson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/7/66	
23C. PHYSICIAN'S NAME (Type) Daniel C. Wilkerson		23D. ADDRESS 421 Regester Ave, Balto.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 10, 1966		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens	
24D. LOCATION Bel Air		(City, town, or county) Harford		(State) Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.	

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BALTIMORE CITY HEALTH DEPARTMENT

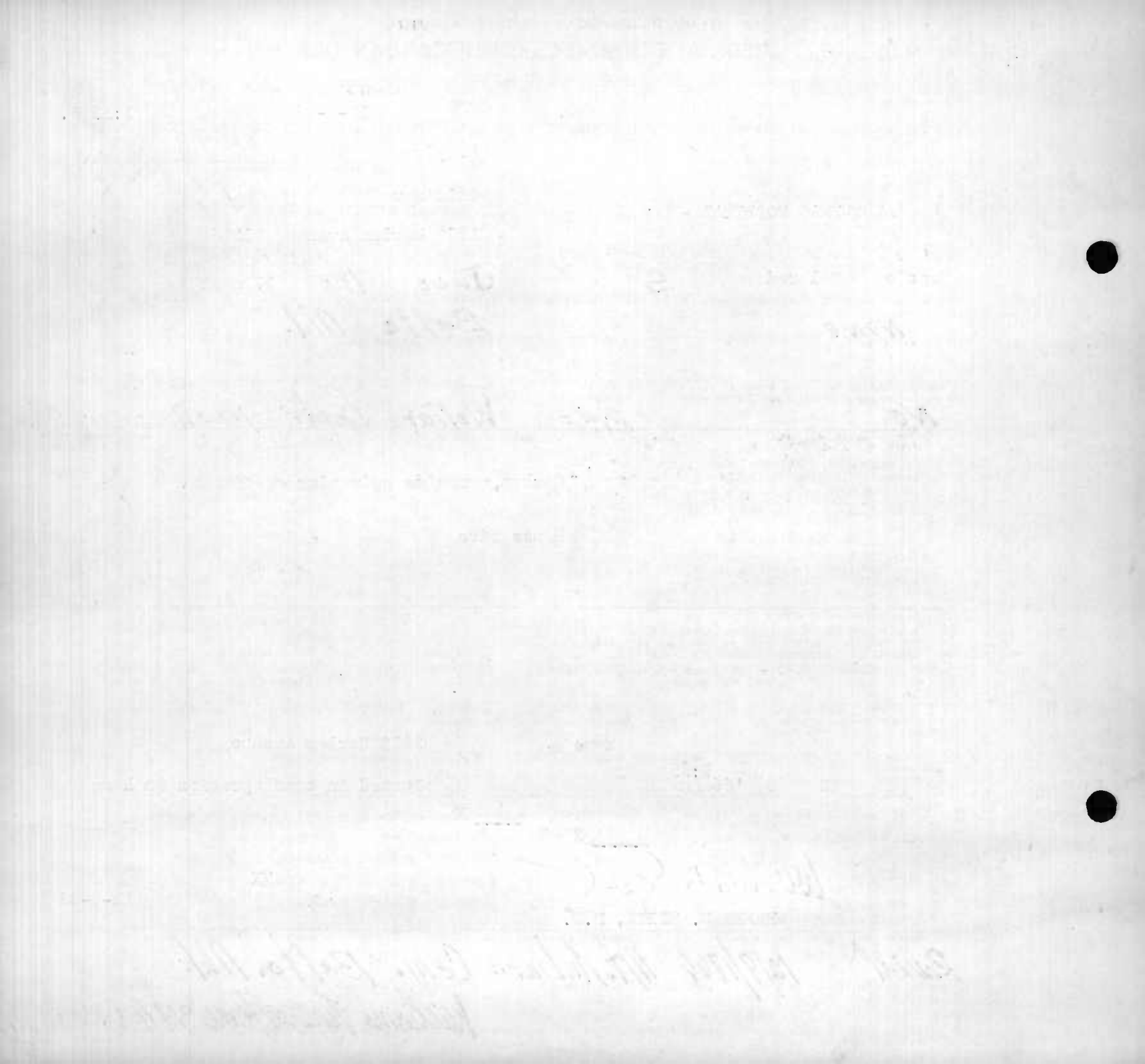
66 12302

BIRTH NO. 65-17854 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

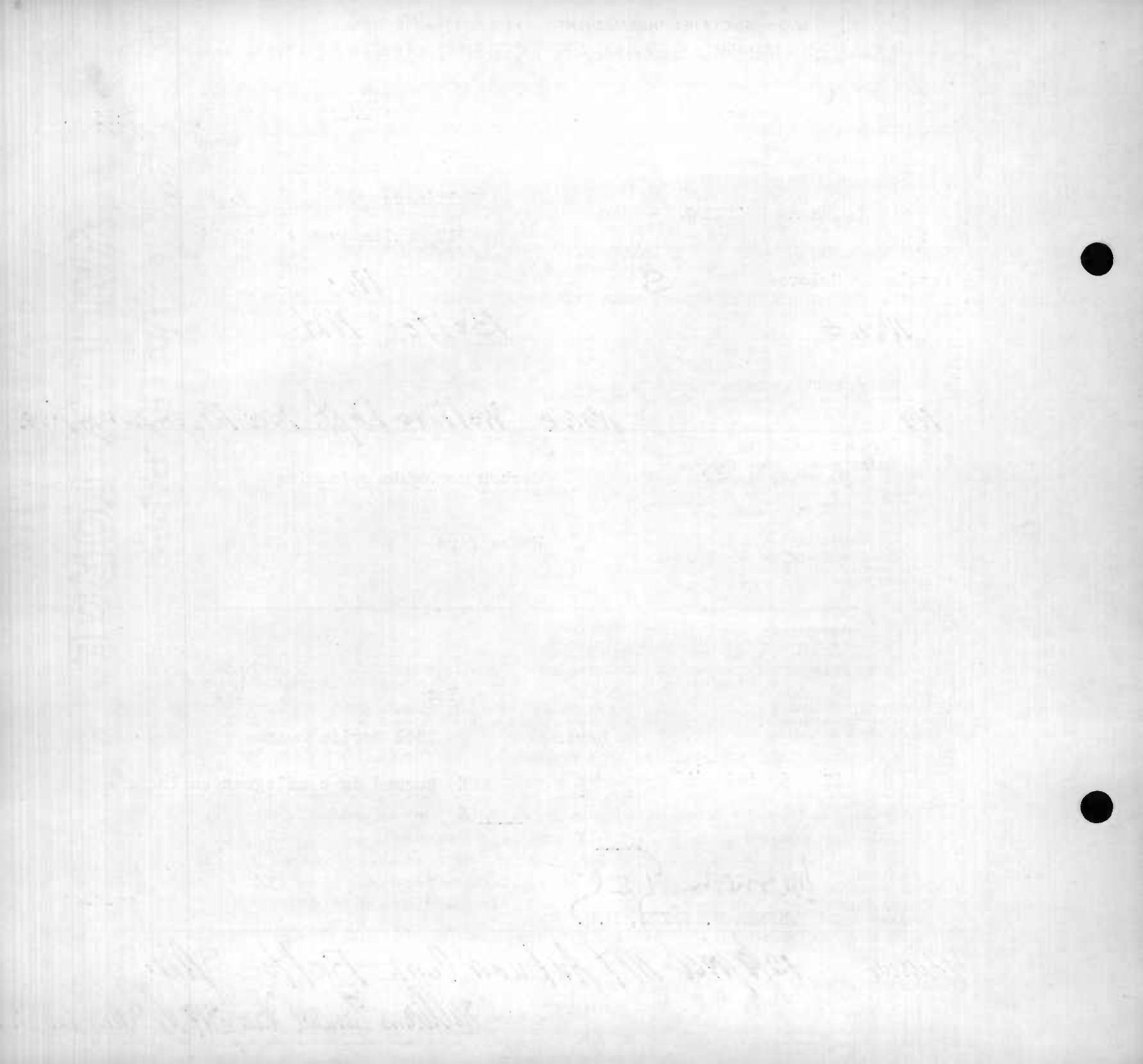
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
ROBBIN JORDAN		12-6-66 7:55 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL - DOA		A. STATE Maryland B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 2812 Harlem Avenue 21216	
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) 3	8. DATE OF BIRTH June 1965 17 months
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Welfare Dept.		ADDRESS 1500 Greenmount Ave	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carbon monoxide poisoning			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. House fire			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
21C. WHERE DID INJURY OCCUR? 2812 Harlem Avenue 16-06			
21D. TIME OF INJURY (APPROX.) 12 6 '66 7:55 AM		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? Burned in conflagration in home			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12-6-66			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 12/9/1966	
23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. DEC 9 1966		24B. NAME OF REGISTRAR R. E. F.	
24C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3197 Schenck St.	

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66 12303		BALTIMORE CITY HEALTH DEPARTMENT		66 12303	
BIRTH NO. 62-33078		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
ANGELA THOMPSON		12-6-66 7:55 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
46 LUTHERAN HOSPITAL - DOA		B. COUNTY			
99		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
		Baltimore 16-06			
		D. STREET ADDRESS (If rural, give location)			
		2812 Harlem Avenue 21216			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	Colored	S	1963	3	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None				Baltimore Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Welfare Dept. 1500 Greenmount Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
E916.0		Carbon monoxide poisoning			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
		(B) House fire			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, steel, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		House		2812 Harlem Avenue 16-06	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour) (Min.) 12 6 '66 7:55 AM		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Burned in conflagration in home	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER		12-6-66	
WERNER U. SPITZ, M.D.		XX			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		12/9/1966		Mt. Auburn Cem. Baltimore Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
DEC 9 1966		Robert E. Fairley, M.D.		Williams Funeral Home 319 N. Schroeder St.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

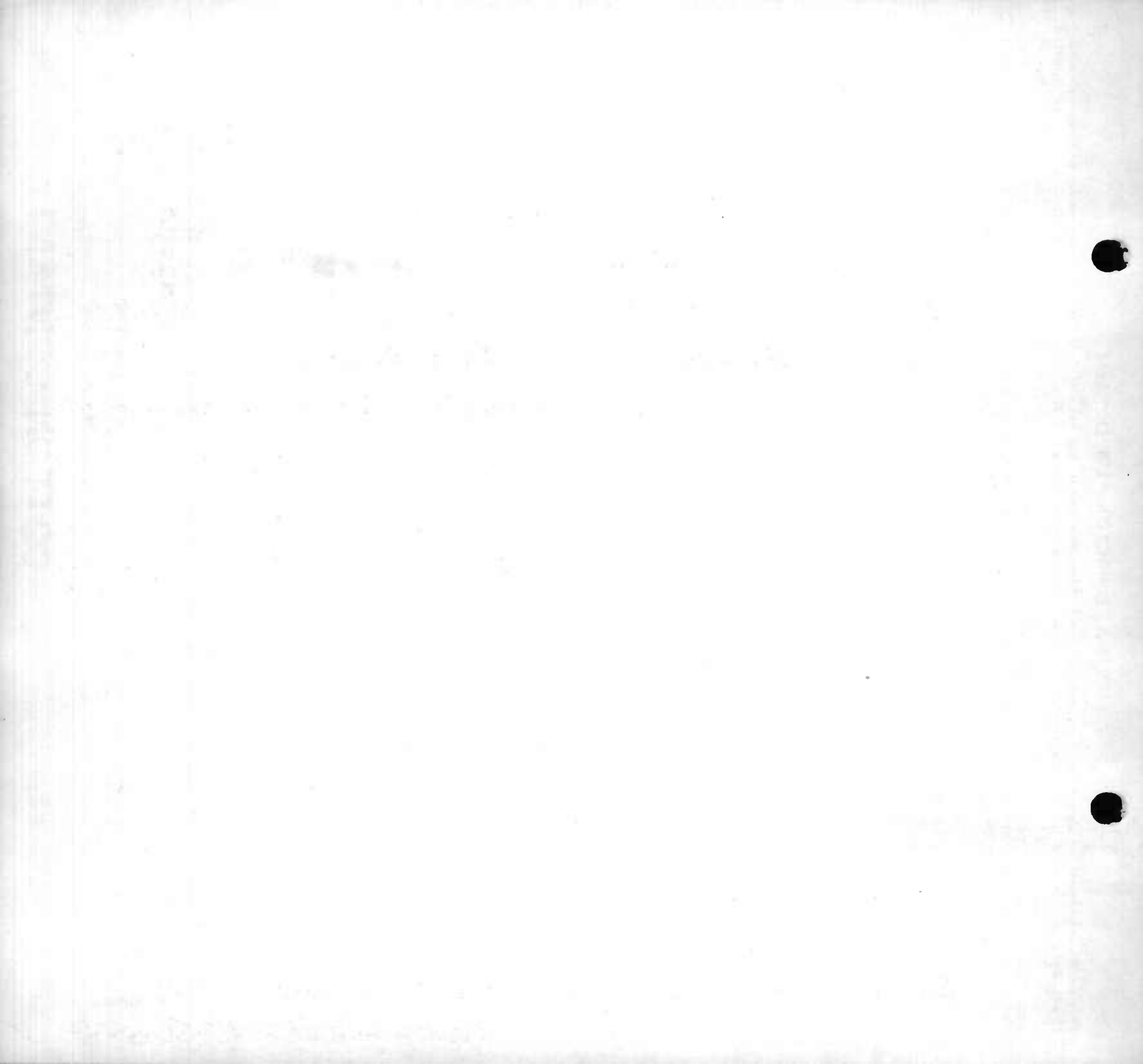
BIRTH NO. 66 12304		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12304	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MITCHELL L. RENE		2. DATE AND HOUR OF DEATH 12-7-1966 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 301 S. CHESTER ST.		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 301 S. CHESTER ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH SEPT. 7, 1896	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY CONFECTIONARY		11. BIRTHPLACE (State or foreign country) MAINE	
13. FATHER'S NAME MITCHELL		14. MOTHER'S MAIDEN NAME DE GONZALEZ			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-07-8492		17. INFORMANT HORTENSE RENE 301 S. CHESTER ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Due to Carcinoma of Esophagus (B) Due to (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1966 to Dec 8 1966, that (I) (we) last saw the deceased alive on 12-8-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore T. Niznyk M.D.		23B. DATE SIGNED 12-9-66			
23C. PHYSICIAN'S NAME (Type) T T NIZNYK M.D.		23D. ADDRESS 429 S Chester St			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-10-66		24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK CEM	
24D. LOCATION BALTO		24E. (City, town, or county)		24F. (State) MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR JOHN M WEBER & SONS INC 401 S. CHESTER ST	

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it sets out the President's policy for the new year. The President states that he is pleased to see the Congress assembled, and that he is confident that the country is in a better position than it was at the beginning of the year. He also states that he is confident that the country is in a better position than it was at the beginning of the year.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

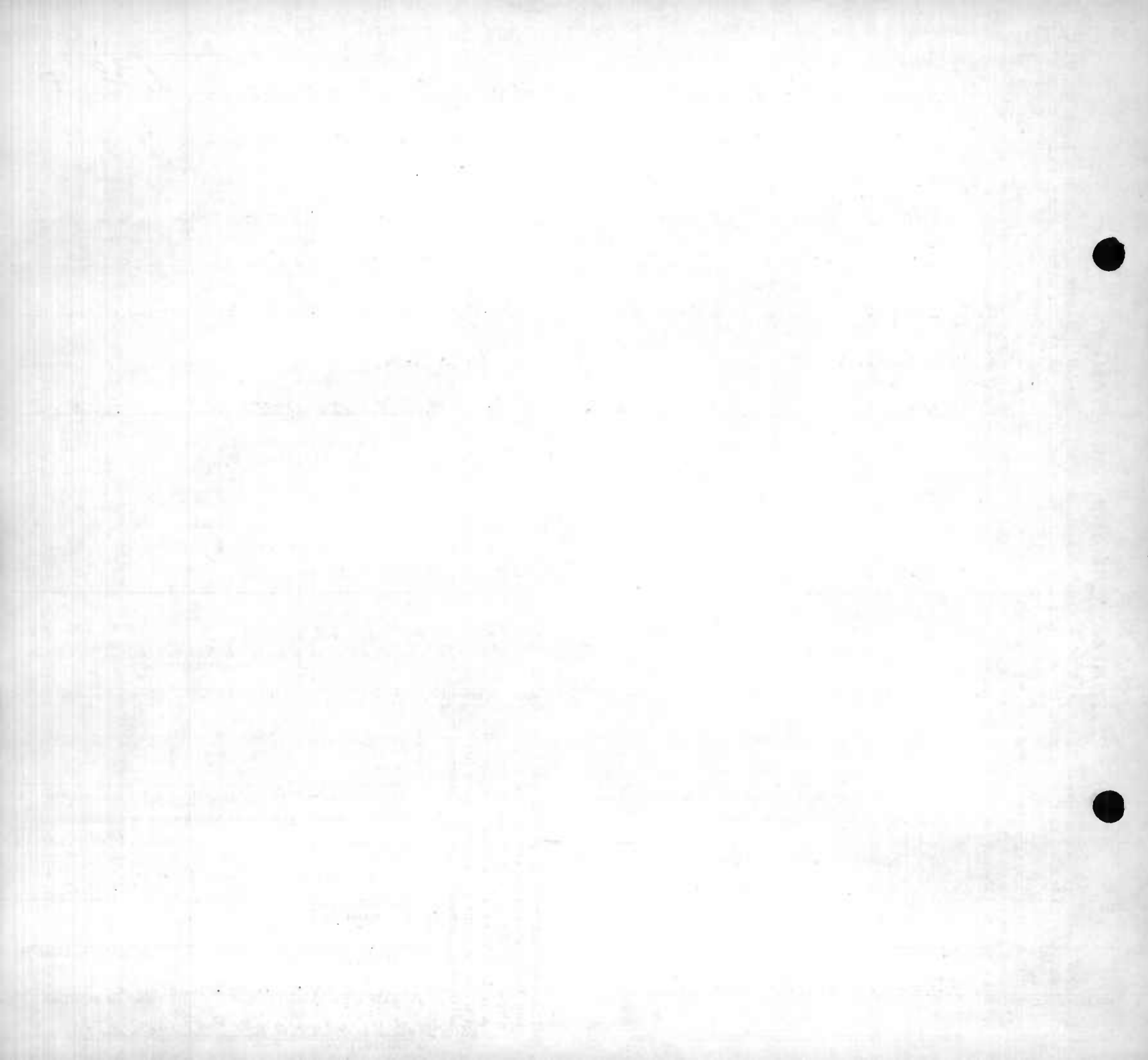
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 12305					CERTIFICATE OF DEATH					Registered No. 66 12305				
1. NAME OF DECEASED (Type or Print) <u>Hardy, Alice</u>					2. DATE AND HOUR OF DEATH <u>Dec. 5, 1966</u> <u>12:15</u> A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-15</u>									
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital of Baltimore</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>									
D. STREET ADDRESS (If rural, give location) <u>Bar Wilba Nursing Home</u>														
5. SEX <u>Fe</u>		6. RACE <u>IV.</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widow</u>		8. DATE OF BIRTH <u>12/29/06</u>		9. AGE (In years last birthday) <u>59</u>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Private</u>					11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>														
13. FATHER'S NAME <u>Ed. Savage</u>					14. MOTHER'S MAIDEN NAME <u>Lula Sanders</u>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>215-227527</u>					17. INFORMANT <u>Mrs Catherine Danks</u>				
					ADDRESS <u>1733 N. Bond St.</u>									
18. <u>260X I</u>					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <u>Acute Renal Failure</u>					<u>1 week</u>				
					(B) <u>Chronic Renal Disease</u>					<u>years</u>				
					(C) <u>Diabetes Mellitus</u>					<u>years</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>11/22</u> 19 <u>66</u> to <u>12/5</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12/5</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.														
23A. SIGNATURE <u>Erwin H. Hesselberg</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>12/5/66</u>				
23C. PHYSICIAN'S NAME (Type) <u>Erwin H. Hesselberg</u>					M.D. <u>Sinai Hospital</u>					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>12-9-66</u>					24C. NAME of CEMETERY or CREMATORY <u>1041 Auburn Cemetery Baltimore, Md.</u>				
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>														
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1966</u>					25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>					25C. FUNERAL DIRECTOR <u>Randolph J. Etlick</u>				
					ADDRESS <u>2431 E. Oliver St.</u>									



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12306		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12306	
M.E. CASE NO.		1. NAME OF DECEASED <i>Janie Henderson</i>		2. DATE AND HOUR OF DEATH <i>12-6-66 10:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>OO</i>		A. STATE <i>Maryland</i> B. COUNTY <i>X</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 5-01</i>			
D. STREET ADDRESS (If rural, give location) <i>1208 H. Court Apt. A-1</i>		<i>1208 H. Court Apt. A-1</i>			
5. SEX <i>Female</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOW</i>	8. DATE OF BIRTH <i>1-15-1898</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Charlotte Court House, Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>UNKNOWN</i>			
14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Annie Farrar</i>			
18. <i>443 XI</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Cerebral Hemorrhage</i> (B) DUE TO <i>Hypertensive Arteriovascular Disease</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 1</i> 19 <i>66</i> to <i>Dec 6</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec 6</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>F. K. Adams</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Dec 9-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>F. K. ADAMS</i>		23D. ADDRESS <i>1222 N. Caroline St.</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>12-9-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Bethel Baptist Cmt'y.</i>	
24D. LOCATION (City, town, or county) (State) <i>Charlotte Court House, Va.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 9 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Randolph Collick</i>			
ADDRESS <i>2431 E. Oliver St.</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12307				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12307	
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Madden</i>				2. DATE AND HOUR OF DEATH <i>12/3/66 11:20 PM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Queerz Ballon Road</i>		B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Sparks Back Co</i>				D. STREET ADDRESS (If rural, give location) <i>33-02</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>12/3/66</i>	9. AGE (In years lost birthday) <i>0</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>baby</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>Alfred Madden</i>			14. MOTHER'S MAIDEN NAME <i>Frances Scott</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <i>773.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Pending Autopsy Pulmonary Hyaline Membrane Disease</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Prematurity</i>				(B) DUE TO <i>Adipolito, M.D.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>Dec 3</i> 19 <i>66</i> to <i>Dec 3</i> 19 <i>66</i> that (1) (we) lost saw the deceased alive on <i>Dec 3</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>M. Querkach</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/3/66</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. <i>ANATOMY BOARD OF MARYLAND</i> <i>JOHNS HOPKINS MEDICAL SCHOOL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12-8-66</i>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>03</i>		ADDRESS <i>MORTUARY SERVICE - BCHD</i>	



Prose

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**FUNERAL DIRECTOR: IMPORTANT**

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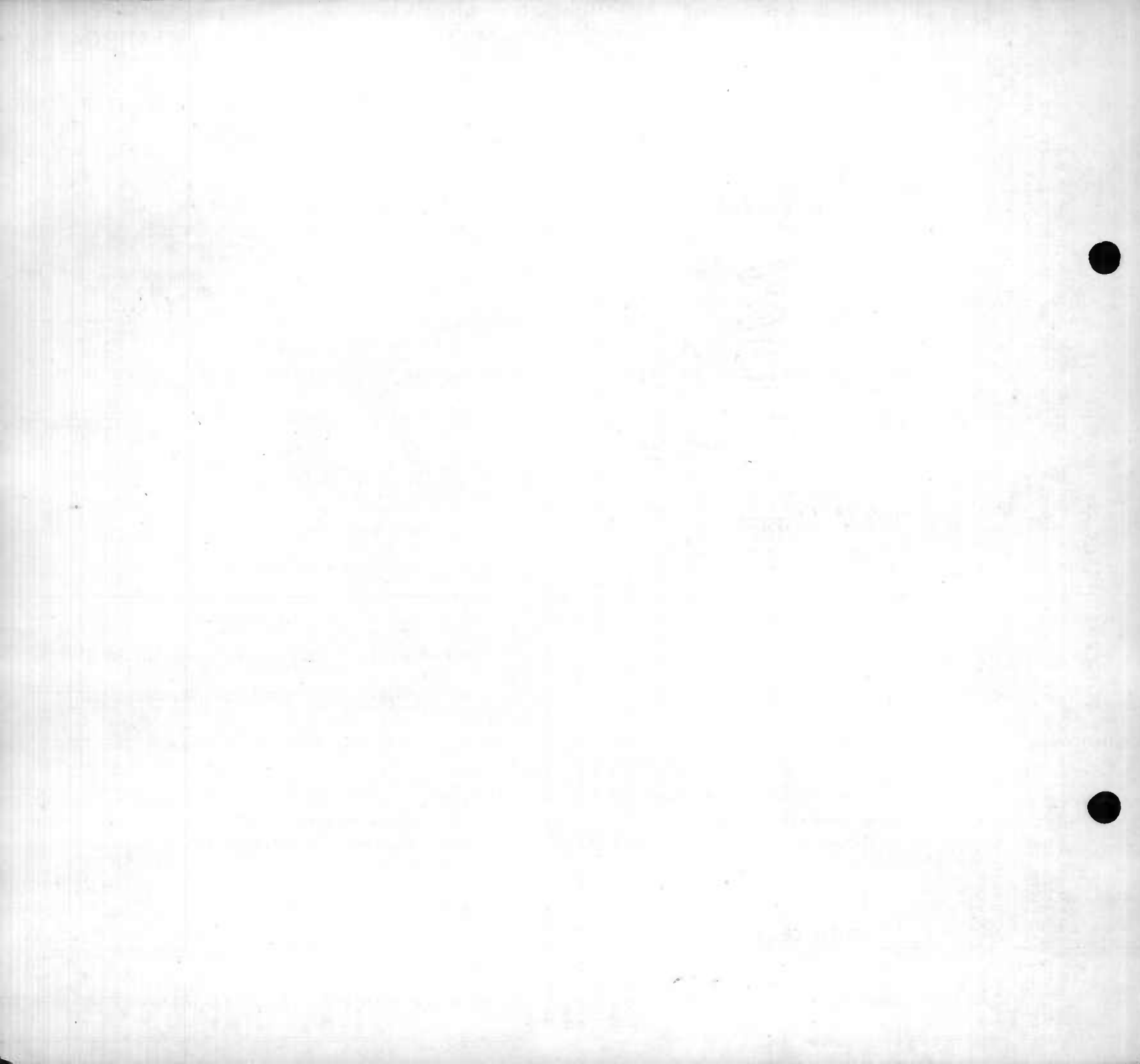
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12308</u>	
BIRTH NO. <u>66-12308</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>66-12308</u>		1. NAME OF DECEASED (Type or Print) <u>Donald K. Wright</u>		2. DATE AND HOUR OF DEATH <u>11/5/66</u> <u>9<sup>25</sup> P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hosp.</u> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>21-01</u> D. STREET ADDRESS (If rural, give location) <u>762 W. Hamburg St. #3</u>			
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED, <u>NEVER MARRIED</u> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>10/13/66</u>	9. AGE (In years last birthday) <u>23</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Single</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Donald I. Wright</u>			14. MOTHER'S MAIDEN NAME <u>Ida Betared</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT ADDRESS <u>D. Gary Benfield MD - UH</u>		
18. <u>764.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH A → <u>Hypernatremia</u> (A) DUE TO B → <u>Diarrhea, Vomiting, &amp; Dehydration</u> (B) DUE TO C → <u>Gastroenteritis</u> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u> <u>48 hr</u> <u>72 hr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>11/3</u> 19 <u>66</u> to <u>11/5</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>11/5</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>D. Gary Benfield</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>11/5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>D. Gary Benfield</u> M.D. <u>University Hosp.</u>				23D. ADDRESS <u>UNIVERSITY MEDICAL SCHOOL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>12-1-66</u>		24B. DATE		24C. NAME of CEMETERY or CREMATORY <u>MORTUARY SERVICE - BLD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, MD</u>		25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">66 12309</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.2em;">63-36130 66 12309</span> <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Sherry Green</span>		<b>CERTIFICATE OF DEATH</b> <b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">11/24/66 5:15 pm</span> <span style="float: right;">M.</span>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">33 The Johns Hopkins Hospital</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <span style="font-size: 1.2em;">Md.</span> <b>B. COUNTY</b> <span style="font-size: 1.2em;">Baltimore</span> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 9-06</span> <b>D. STREET ADDRESS</b> (If rural, give location) <span style="font-size: 1.2em;">2854 Harford Rd #8</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">N</span>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <span style="font-size: 1.2em;">—</span>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">12/30/63</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">2 1/2</span>	<b>10. UNDER 1 Yr. Months: Days</b> <b>11. UNDER 24 Hrs. Hours: Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">child</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">—</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Md.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Therell Green</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Jannie</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">—</span>			<b>17. INFORMANT ADDRESS</b>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">754.41 Endocardial Fibroelastosis 2 yr.</span> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">2 yr.</span>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <span style="font-size: 1.2em;">Question of digitalis toxicity 2 days</span>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">—</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">—</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <span style="font-size: 1.2em;">—</span>		<b>21. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <span style="font-size: 1.2em;">No</span>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">—</span>			
<b>21C. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.) <span style="font-size: 1.2em;">—</span>		<b>21D. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21E. HOW DID INJURY OCCUR?</b> <span style="font-size: 1.2em;">—</span>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10/12</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">11/24</span> 19 <span style="font-size: 1.2em;">66</span>.</b> <b>that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">11/24</span> 19 <span style="font-size: 1.2em;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">John Johnson M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">11/24/66</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">John Johnson</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">House staff Dept. Pediatrics, Johns Hopkins Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">12-6666</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">12-6666</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">—</span>	
<b>24D. LOCATION</b> (City, town, or county) (State)		<b>25. FUNERAL DIRECTOR ADDRESS</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">DEC 9 1966</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Farley</span>		<b>25C. FUNERAL SERVICE - BOND</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Lula Brown

2. DATE AND HOUR PRONOUNCED DEAD

11/22/66 9:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

1203

D. STREET ADDRESS (If rural, give location)

872½ W. Pierce St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

81?

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/22/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

12-6-66

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 9 1966

Robert E. Taylor

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BEND

THE UNIVERSITY OF CHICAGO

LIBRARY

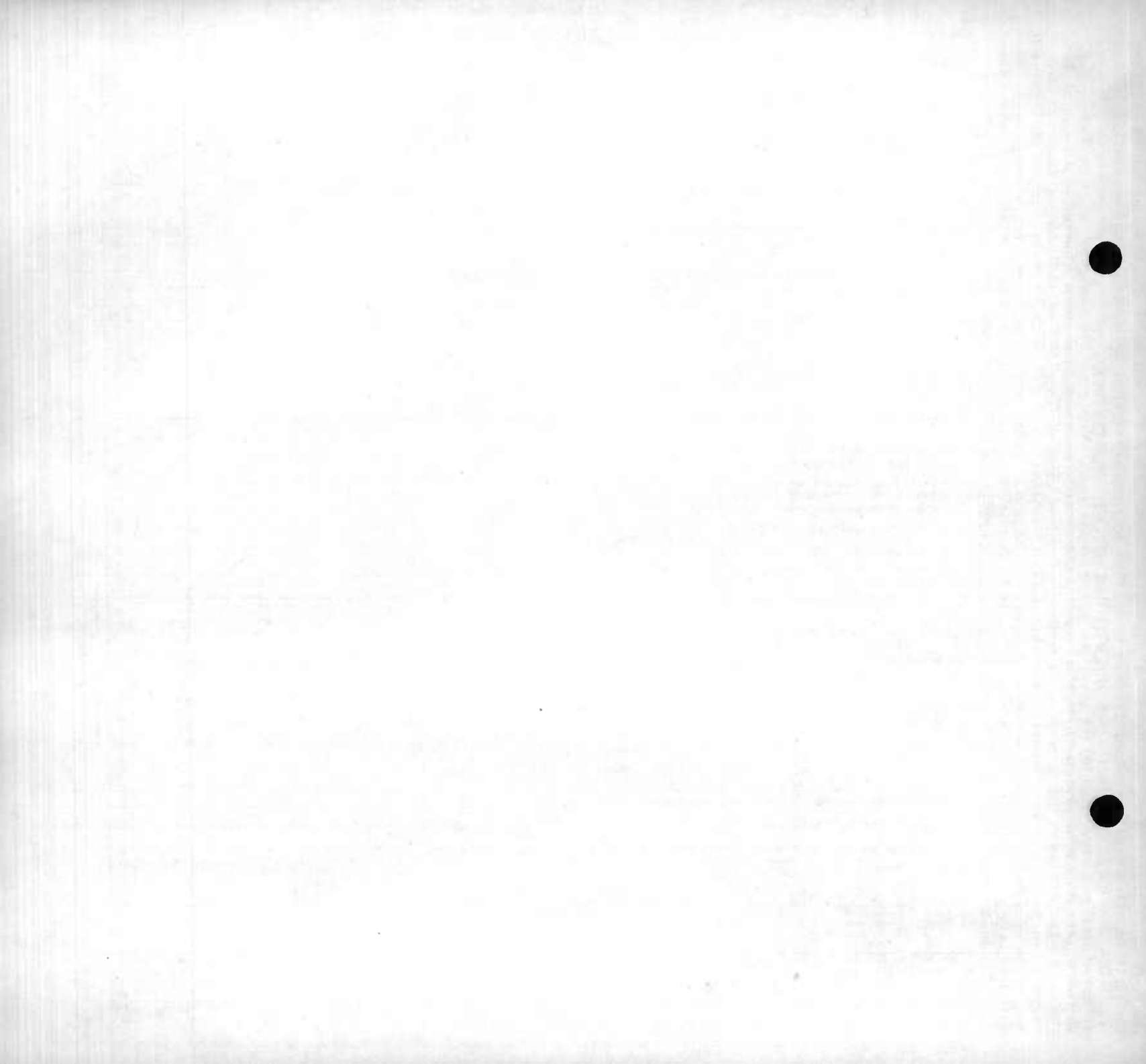
1967

1967

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 66 12311	
CERTIFICATE OF DEATH					
BIRTH NO. 66 12311		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>Baby Boy Burch</b>		2. DATE AND HOUR OF DEATH <b>11-22-66 11030 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 University Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Balto.</b> B. COUNTY <b>Maryland</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <b>1716 W Fayette St.</b>			
5. SEX <b>Male</b>	6. RACE <b>negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>11-22-66</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>15</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Dan Burch</b>			
14. MOTHER'S MAIDEN NAME <b>Holloman, Eva</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>276 X I</b>		CAUSE OF DEATH (A) DUE TO <b>immaturity</b> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19____ to 19____, that (I) (we) last saw the deceased alive on 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Carl H. Francis</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-22-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>EARLIE H. Francis</b>		23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-1-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 9 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BORD</b>			





1  
66 12312  
H-530

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12312

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Roy Hundley

2. DATE AND HOUR PRONOUNCED DEAD

11/22/66 10:05 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 Louis Hotel

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday) 49If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty alteration of liver  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/22/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

VALLEY POLE  
WILLIAM J. JONES  
CHAS. R. JONES

66 12313

BALTIMORE CITY HEALTH DEPARTMENT

66 12313

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LEONARD

BROWN

2. DATE AND HOUR PRONOUNCED DEAD

December 7, 1966

5:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1939 W. Lafayette Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1939 W. Lafayette Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov 27, 1912

9. AGE (in years  
lost birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Presser

10B. KIND OF BUSINESS OR INDUSTRY

Coat Co.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Walter Brown

14. MOTHER'S MAIDEN NAME

Ada Tablot

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.11

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Ruth A. Brown 3920 Woodridge Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary Tuberculosis, Massive, Active.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/12/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 9 1966 R. E. F. F. F.

Herbert E. Nutter 3035 W. North Ave.

WALLACE BODIN

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12314				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 12314	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>John G. Thornton</u>				2. DATE AND HOUR OF DEATH <u>12-6-66</u> <u>9:00 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u>		(If not in hospital or institution, give street address or location) <u>LITTLE SISTERS OF THE POOR</u> <u>1200 VALLEY STREET</u> <u>BALTIMORE, MD. 21202</u>		A. STATE <u>MD.</u>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, give rural and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>1200 VALLEY STREET</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>3-28-1890</u>	9. AGE (In years last birthday) <u>76</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WALLACE</u>				14. MOTHER'S MAIDEN NAME <u>AGNES ROCHE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-02-8233A</u>		17. INFORMANT ADDRESS <u>LITTLE SISTERS OF THE POOR</u>			
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <u>acute myocardial infarction</u> <u>Cor - pulmonale</u> <u>C.S.C.V.D.</u> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>Dec 6</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 6</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Stanley Ankudas</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12.7.66</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANLEY ANKUDAS</u>				23D. ADDRESS M.D. <u>1101 MAIDEN CHOICE LANE - BALTIMORE, MD.</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/9/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Philip Herwigson</u>		ADDRESS <u>2024 Orleans St</u>	

1925  
Oct 1 - Dec 1  
1925

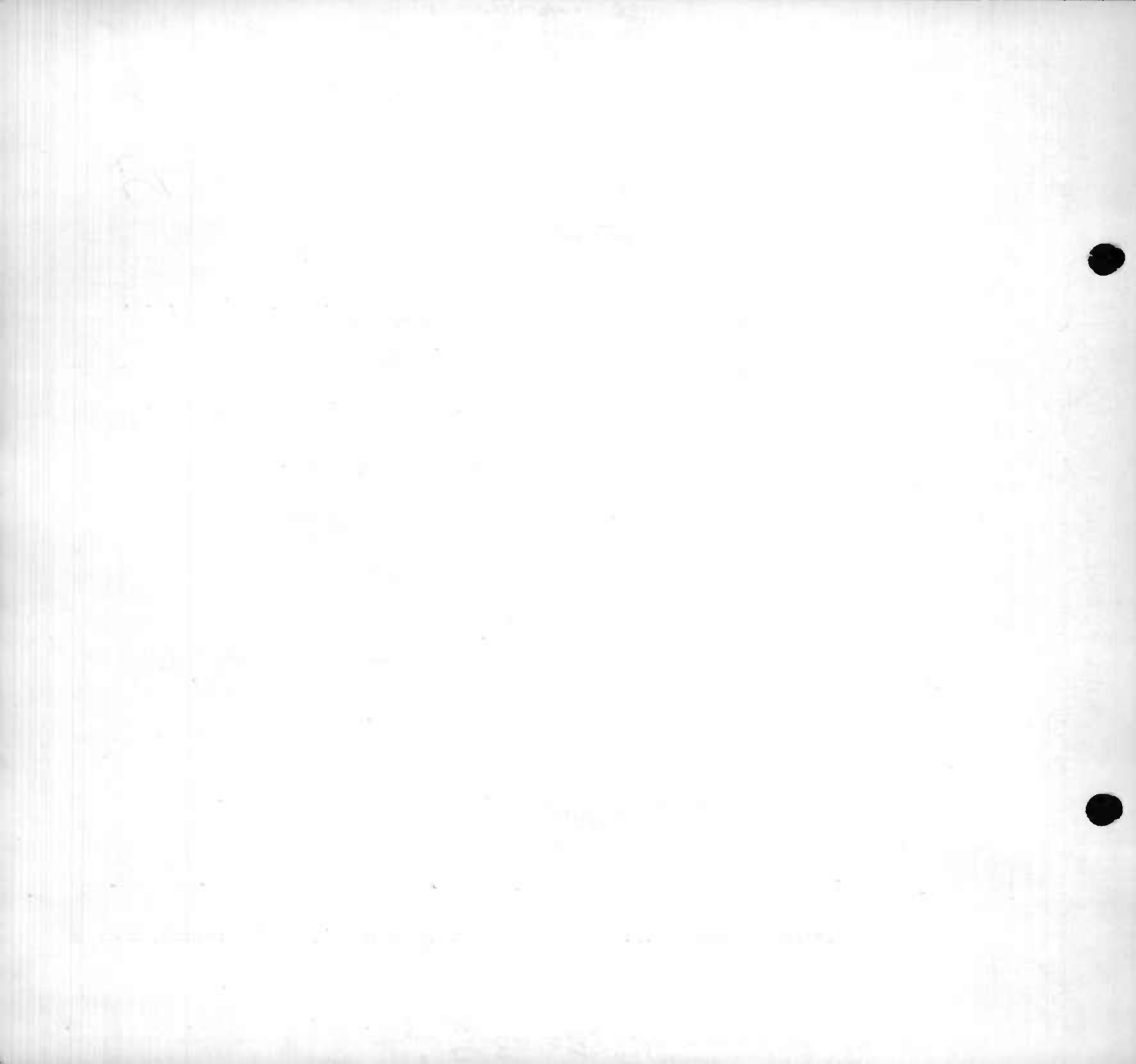
Henry (Graham)

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12315				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12315	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Aaron Grandison				2. DATE AND HOUR OF DEATH 12-6-66 4:45 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-47 D. STREET ADDRESS (If rural, give location) 3308 Elgin Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 9-28-1897	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10B. KIND OF BUSINESS OR INDUSTRY Sheppard Pratt-Hosp		11. BIRTHPLACE (State or foreign country) Gloucester Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jefferson Grandison				14. MOTHER'S MAIDEN NAME Sarah Moody			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-32-1250		17. INFORMANT ADDRESS Mrs. Ida Johnson-3308 Elgin Ave.			
18. 442 X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic duodenal ulcer Ulcer Rt foot				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 10/26/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ulcer right leg		20A. AUTOPSY? <input checked="" type="checkbox"/> Yes or <input type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec. 5 19 66 to Dec. 6 19 66, that (I) (we) last saw the deceased alive on Dec 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Irving Freeman				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/6/66	
23C. PHYSICIAN'S NAME (Type) Irving Freeman, M.D.				23D. ADDRESS Lutheran Hospital of Maryland, Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/66		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farkley		25C. FUNERAL DIRECTOR Herbert E. Nutter -3035 W. North Ave.		ADDRESS	

DEC 9 1966

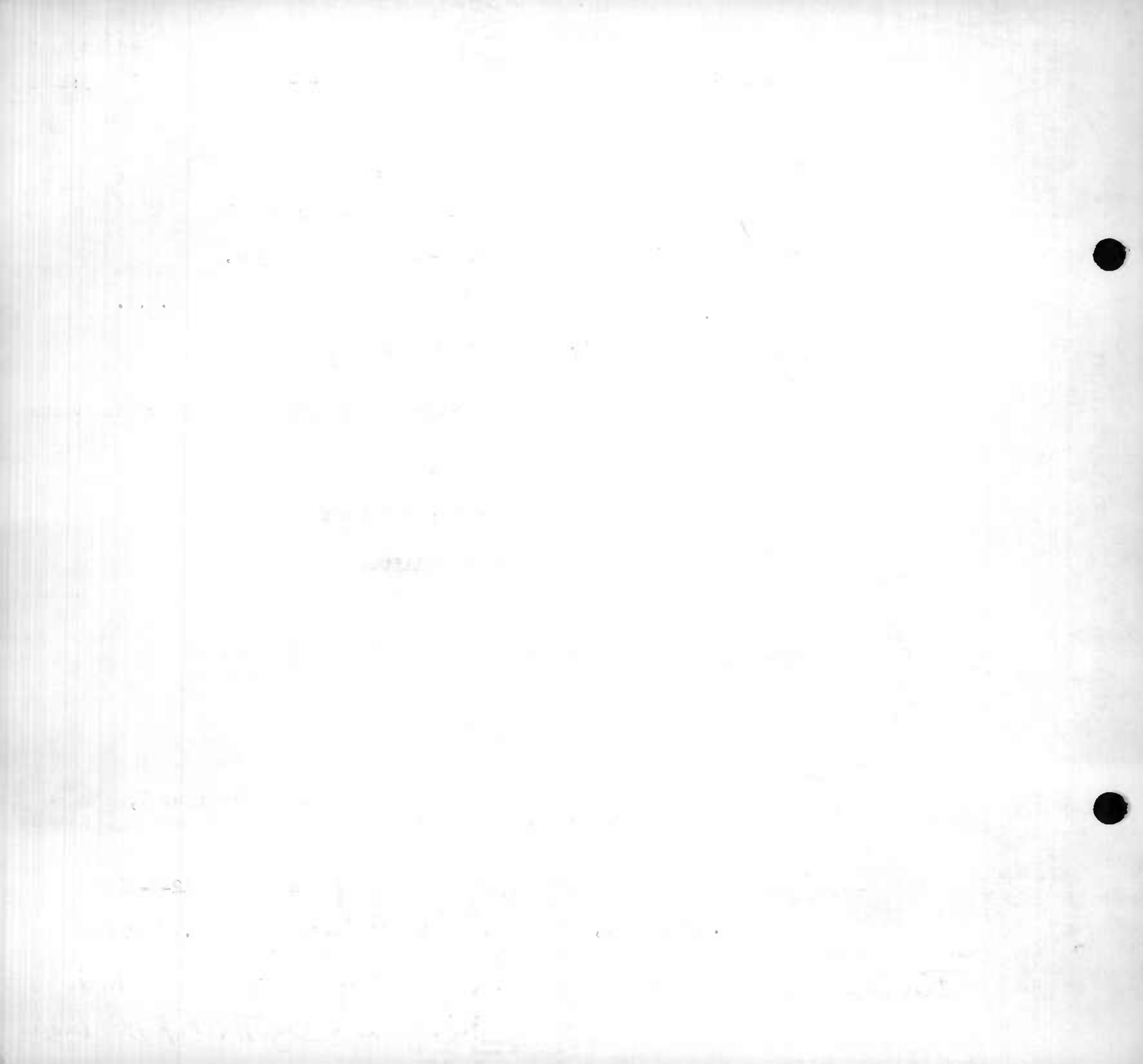




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

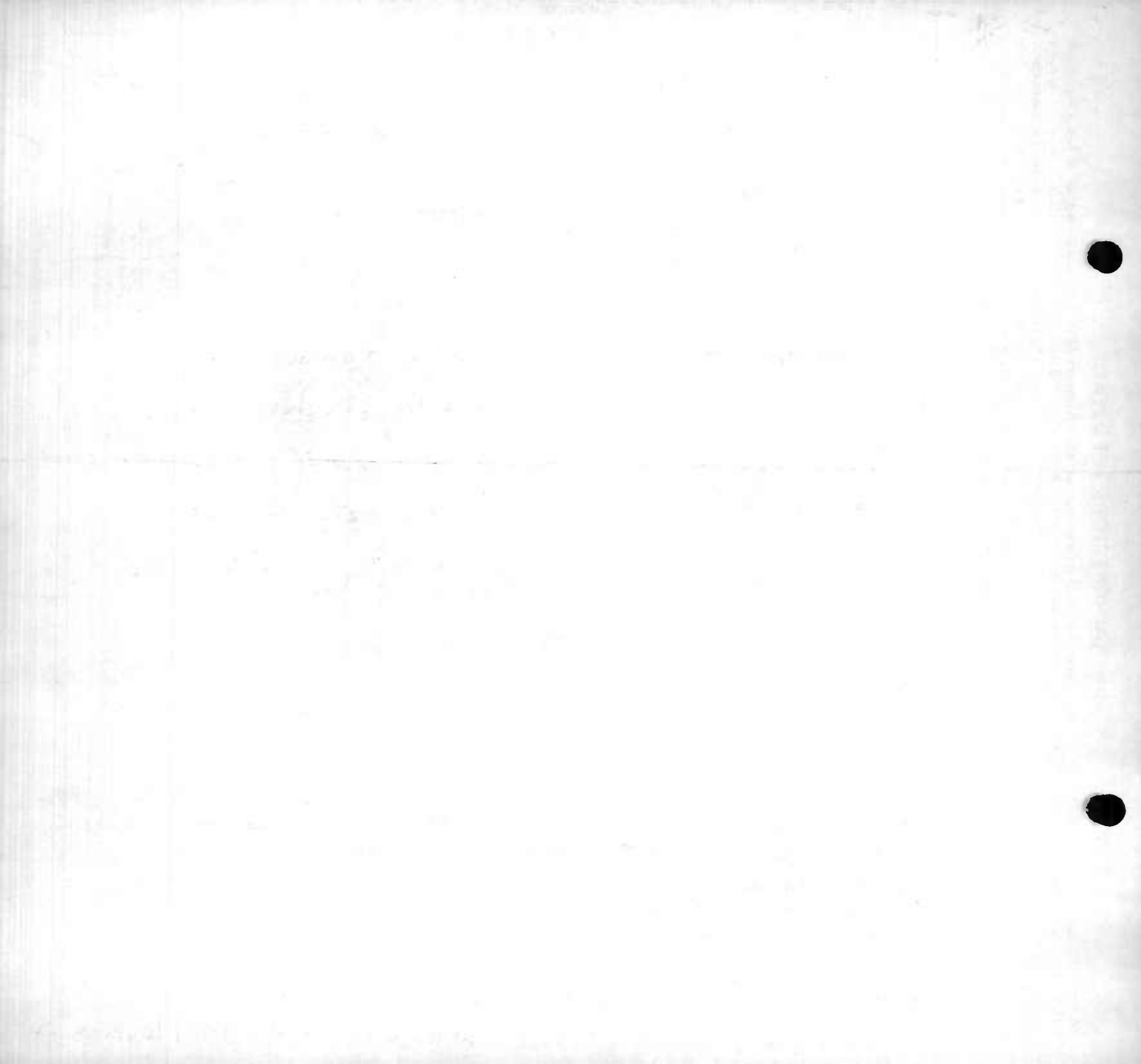
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12316</span>	
BIRTH NO. <span style="float: right;">66 12316</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="float: right;">Mae Pack</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">12-7-66 5:10 P.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">Provident Hospital</span>		A. STATE <span style="float: right;">Maryland</span> B. COUNTY			
39		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">Baltimore,</span>			
		D. STREET ADDRESS (If rural, give location) <span style="float: right;">17-02</span> <span style="float: right;">1314 Division Street</span>			
5. SEX <span style="float: right;">Female</span>	6. RACE <span style="float: right;">Negro</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="float: right;">Widowed</span>	8. DATE OF BIRTH <span style="float: right;">10-9-12</span>	9. AGE (In years last birthday) <span style="float: right;">54 yrs.</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Nurse</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Private Duty</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Virginia</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>		13. FATHER'S NAME <span style="float: right;">George Tankard</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Alice Brooks</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="float: right;">Pauline Jones (Niece) 1000 McKean Avenue</span>	
18. <span style="float: right;">260X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <span style="float: right;">Septicemia</span> DUE TO <span style="float: right;">Cellulitis, right leg</span> (B) <span style="float: right;">Diabetes Mellitus</span> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="float: right;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">December 3, 1966</span> to <span style="float: right;">December 7, 1966</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">December 7, 1966</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">J. Malabrigo</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="float: right;">12-8-66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">J. Malabrigo,</span>		23D. ADDRESS <span style="float: right;">1514 Division Street Balto., Maryland</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">12-10-66</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">MT. CALVARY</span>	
24D. LOCATION (City, town, or county) (State) <span style="float: right;">A.A. Co. Md.</span>		25A. DATE RECEIVED BY HEALTH DEPT. <span style="float: right;">DEC 9 1966</span>		25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Farber, MA</span>	
25C. FUNERAL DIRECTOR <span style="float: right;">MORTON &amp; DYE</span>		25D. ADDRESS <span style="float: right;">F.H. 1701 LAURENS</span>			



# FUNERAL DIRECTOR: IMPORTANT

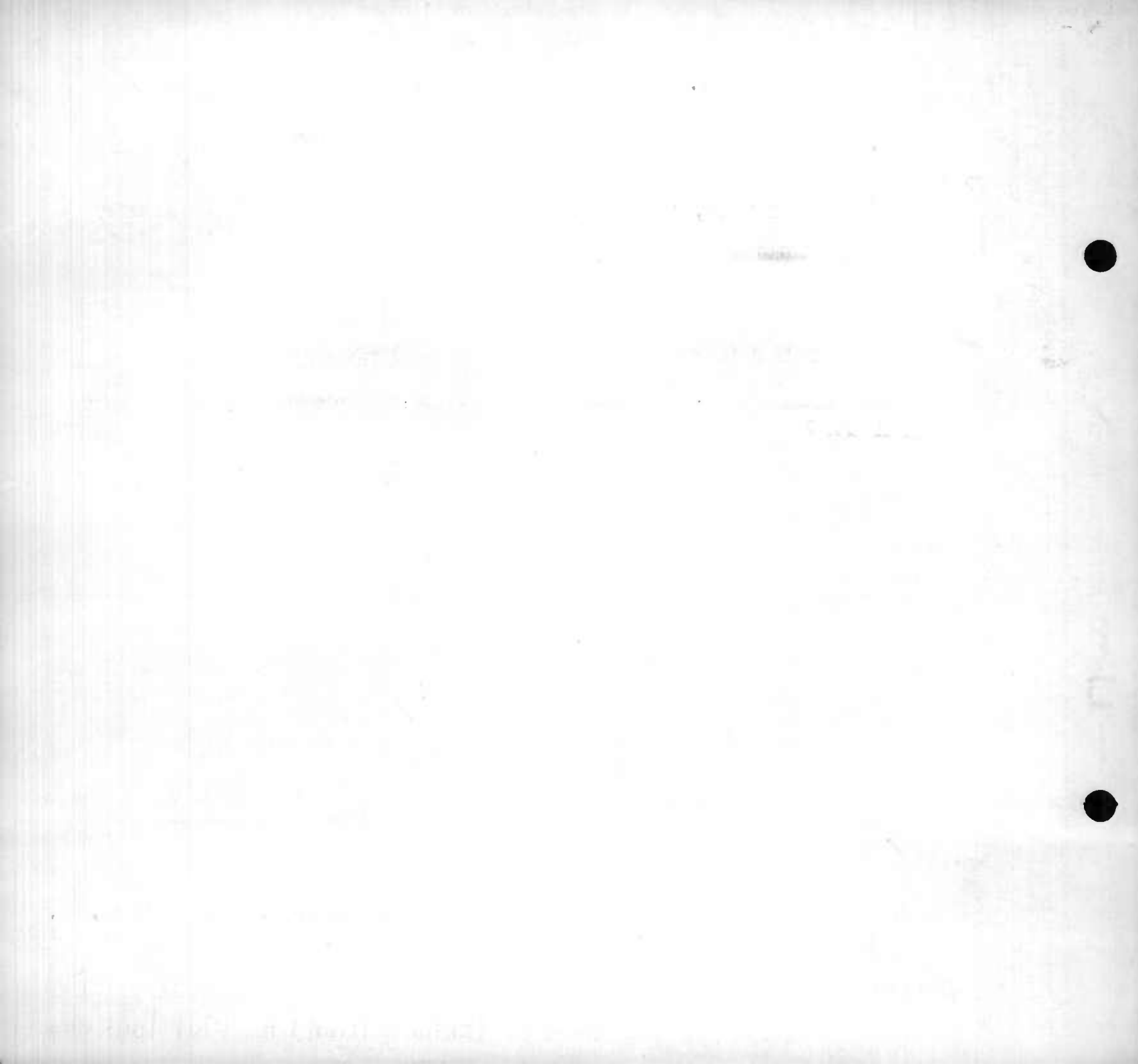
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 12317	
BIRTH NO. 66 12317		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MARY BUCHANAN</b>		2. DATE AND HOUR OF DEATH <b>12/8/66</b> <span style="float: right;">1 1<sup>05</sup>/<sub>A</sub> M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI Hospital of Baltimore, Inc.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>WHITE HALL</b> D. STREET ADDRESS (If rural, give location) <b>Anderson Road</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>3/3/05</b>	9. AGE (In years lost birthday) <b>61</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Sydney</b>			14. MOTHER'S MAIDEN NAME <b>Susie Ramson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Richard Buchanan Whitehall, Md.</b>	
18. <b>422111</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARRHYTHMIA</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>CONGESTIVE HEART FAILURE</b> DUE TO		<b>3 weeks</b>	
		(C) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> DUE TO		<b>YEARS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>GOUTY NEPHRITIS</b>			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>2</b> (this hospital) attended the deceased from <b>11/18</b> 19 <b>66</b> to <b>12/8</b> 19 <b>66</b> , that <b>9</b> (we) last saw the deceased alive on <b>12/8</b> 19 <b>66</b> and that in (my) <b>and</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> (did) <b>(did not)</b> view the body after death.					
23A. SIGNATURE <b>G. Brett Lazar</b>				23B. DATE SIGNED <b>12/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. BRETT LAZAR</b>		23D. ADDRESS <b>SINAI Hosp. of Baltimore, Inc.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>12-12-66</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Pinney Grove Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Whitehall Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Morton E. Dyett F.H.</b> ADDRESS <b>1701 Laurens St</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

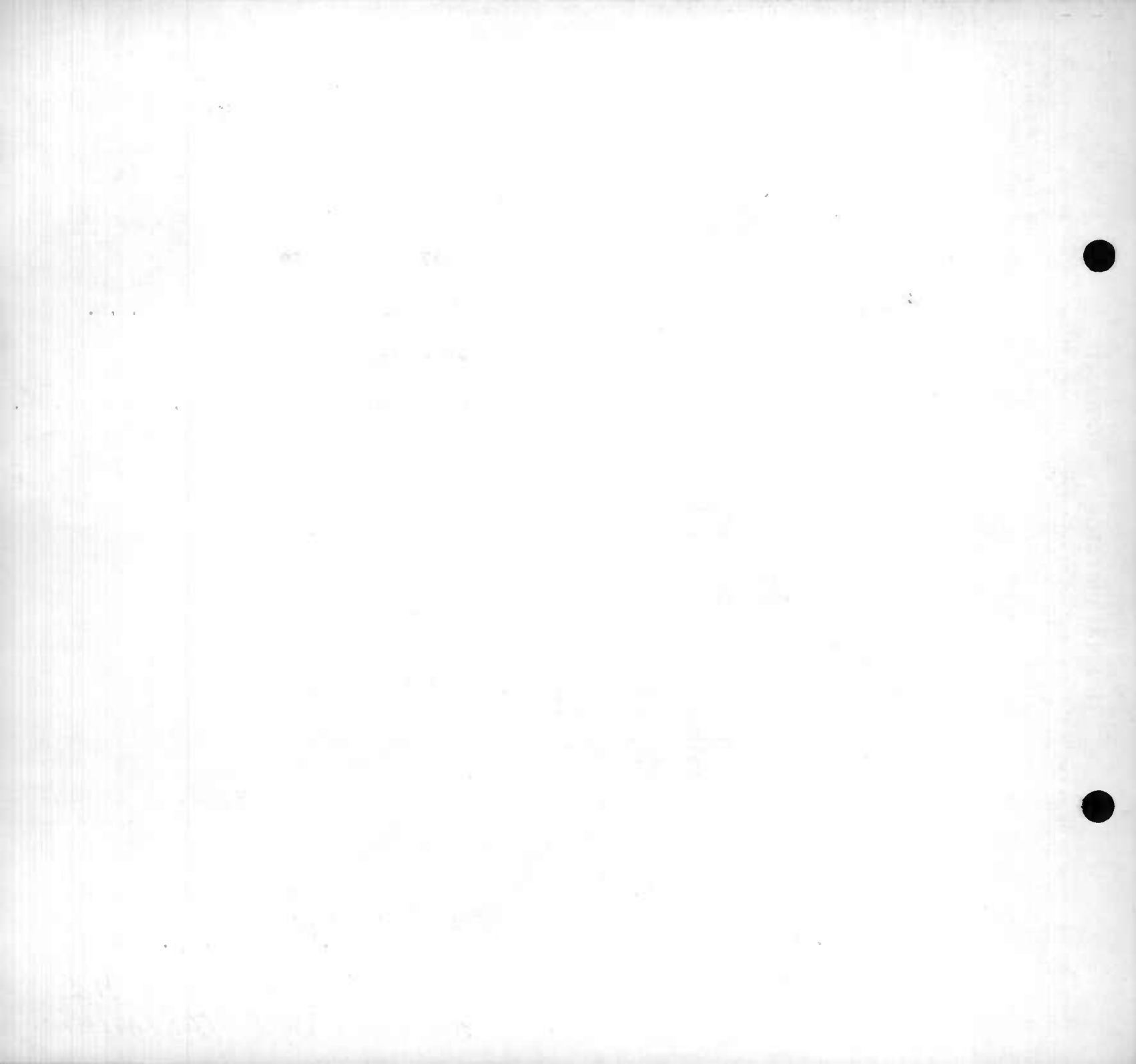
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12318	
BIRTH NO. 66 12318		CERTIFICATE OF DEATH		Registered No. 66 12318	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) James C. Gales		2. DATE AND HOUR OF DEATH 2:30 PM 12/6/66 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. M.D. 12/6/66	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
1 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Baltimore		73 N. Monastery Ave. 21229	
6. SEX male	7. RACE NEGRO	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married	9. DATE OF BIRTH 1-2-02	10. AGE (In years last birthday) 64	11. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) brick molder		10B. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Elais Gales		14. MOTHER'S MAIDEN NAME Serena Jackson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Chronic bronchitis and emphysema (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 6 19 66 to Dec 6 19 66, that (I) (we) last saw the deceased alive on Dec 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Bruce M. Dow		23B. DATE SIGNED 12/6/66	
23C. PHYSICIAN'S NAME (Type) BRUCE M. DOW		23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. BALTIMORE CITY HOSPITALS 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-66		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery Baltimore Md.	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Morton E. Dyett	
24G. FUNERAL DIRECTOR ADDRESS 1701 Laurens St.		24H. DATE REC'D BY HEALTH DEPT.		24I. NAME OF REGISTRAR Morton E. Dyett	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 452 66 12319		BALTIMORE CITY HEALTH DEPT.		Registered No. 66 12319	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>ESTHER WILLIAMS</b>			2. DATE AND HOUR OF DEATH <b>7 DECEMBER 1966 10 45 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSITUATION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b> <b>Baltimore, Maryland # 21224</b>			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>528 Main Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12/2/97</b>	9. AGE (In years last birthday) <b>69</b>	10. Under 1 Yr. Months Days Hours Min. <b>11 Under 24 Hrs. Min.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Clem</b>		
14. MOTHER'S MAIDEN NAME <b>NANNIE ARVIN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>BCH: RECORDS; 4940 Eastern Ave. Baltimore, Md.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>434.1 I</b> <b>INFARCT OF BOWEL</b> DUE TO <b>CHF</b> INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7 DECEMBER 1966</b> to <b>7 DECEMBER 1966</b> , that (I) (we) last saw the deceased alive on <b>7 DECEMBER 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Daniel D. Foote</b> M.D.				23B. DATE SIGNED <b>7 DECEMBER 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Daniel D. Foote</b>				23D. ADDRESS M.D. <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave. Baltimore, Md. # 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-12-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY</b>	
24D. LOCATION <b>A.A. Co.</b>		24E. CITY, TOWN, or COUNTY <b>Md.</b>		24F. STATE <b>Md.</b>	
25A. DATE REG'D BY HEALTH DEPT. <b>DEC 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>MORTON J. Dyer</b>	
25D. ADDRESS <b>1701 LAURENS</b>					





BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LOTTIE

WHITE

2. DATE AND HOUR PRONOUNCED DEAD

December 7, 1966

5:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1523 N. Bethel Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Sept. 22, 1931

9. AGE (In years  
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Hamover, Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Lemuel Burley

14. MOTHER'S MAIDEN NAME

Alice Burley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Carrie V. Strans - Ashland, Va.

18.

E 983X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Craniocerebral Injury.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Found in Field

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
Found - West of Monroe St. &  
North of Balto. Wash. Expressway.

21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

11 20 '66 A

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Struck on head with brick.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-12-66

23C. NAME OF CEMETERY or CREMATORY

Provident Cem.

23D. LOCATION

Ashland, Va.

24A. DATE REC'D BY HEALTH DEPT.

DEC 9 1966

24B. NAME OF REGISTRAR

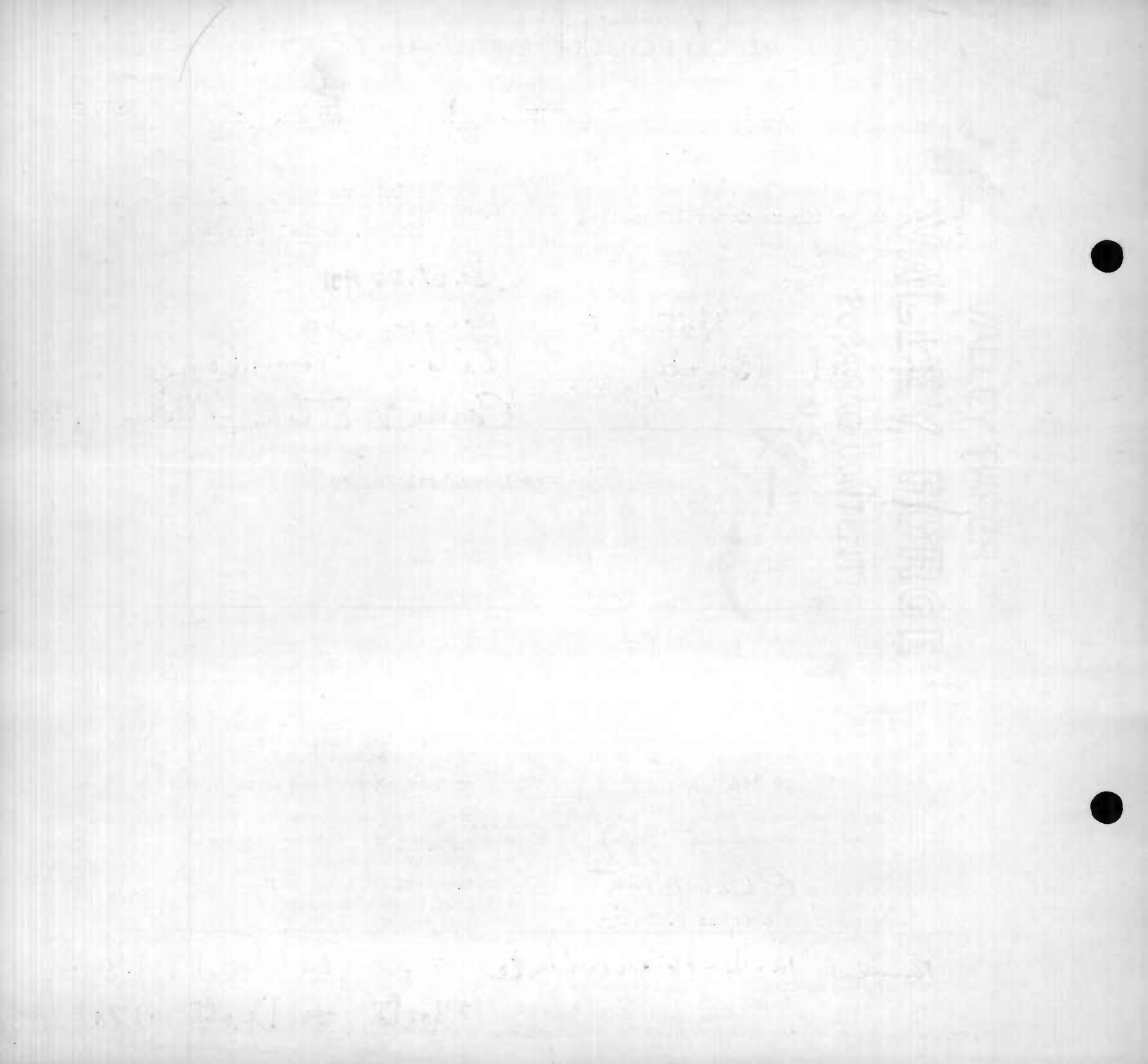
Robert E. Farkas

24C. FUNERAL DIRECTOR

Morton + Dyett

ADDRESS

1701 Lane

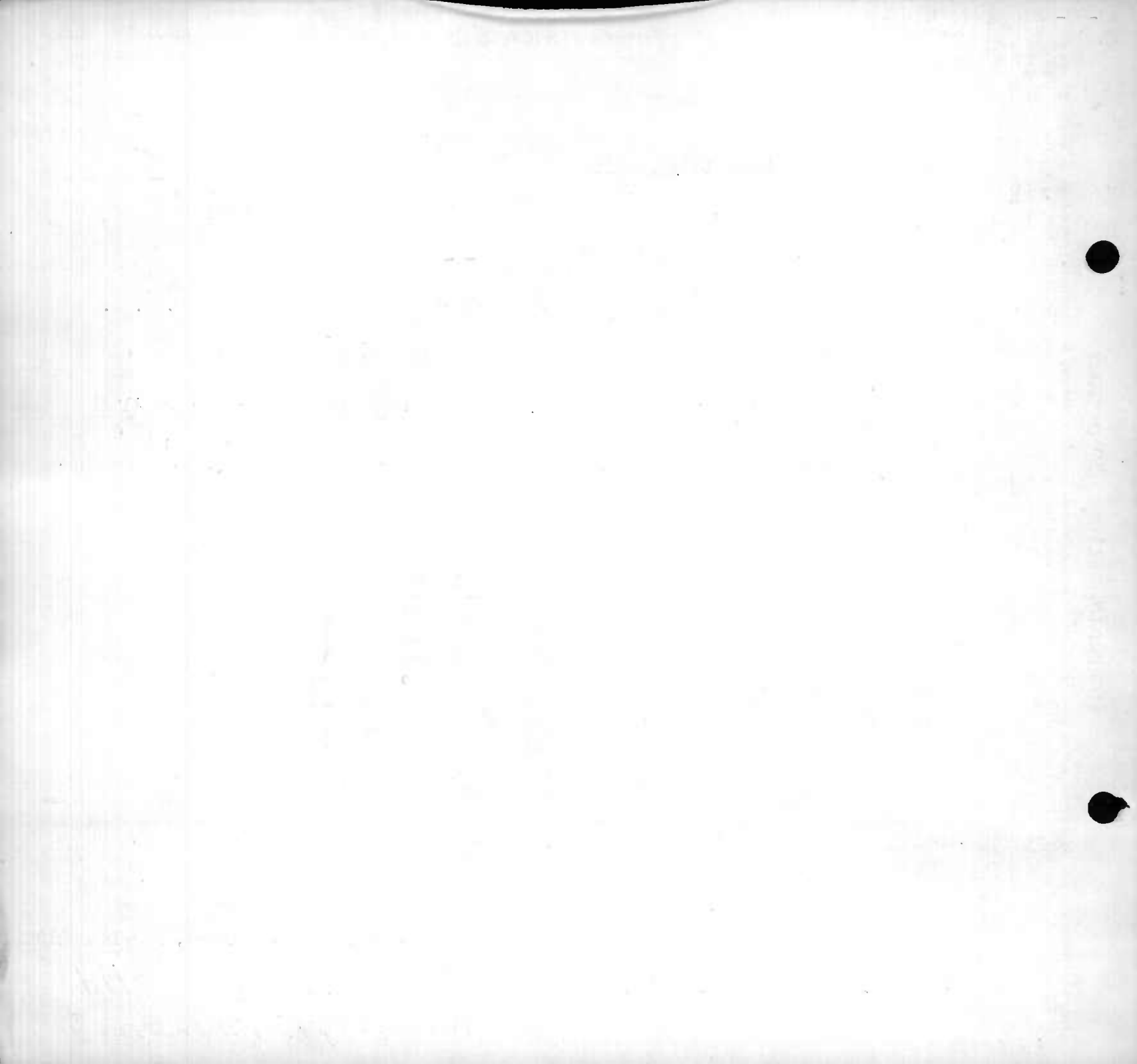


47-99-62  
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12321		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12321	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Anderson, James		2. DATE AND HOUR OF DEATH 12-6-66 12:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. STREET ADDRESS (If rural, give location) 141 Fleming Drive 21222		E. CITIZEN OF WHAT COUNTRY? U. S. A.	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-6-1906	9. AGE (In years last birthday) 60	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beth Steel
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME UNK.	
14. MOTHER'S MAIDEN NAME Rebeca Anderson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 228-189995	
17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma, Unknown CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH Known 6 weeks		19. DATE OF OPERATION 10-26-66	
20. AUTOPSY? (Yes or No) No		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22. I certify that (I) (this hospital) attended the deceased from 10-26-66 to 12-6-66, that (I) (we) last saw the deceased alive on 12-6-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE David Mishelovich		23B. DATE SIGNED 12-6-66		23C. PHYSICIAN'S NAME (Type) David Mishelovich	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-10-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. PK.	
24D. LOCATION Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1966		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR MORTON & Dyett		25D. ADDRESS 1701 LAURENS ST.		25E. DATE OF DEATH 12-6-66	

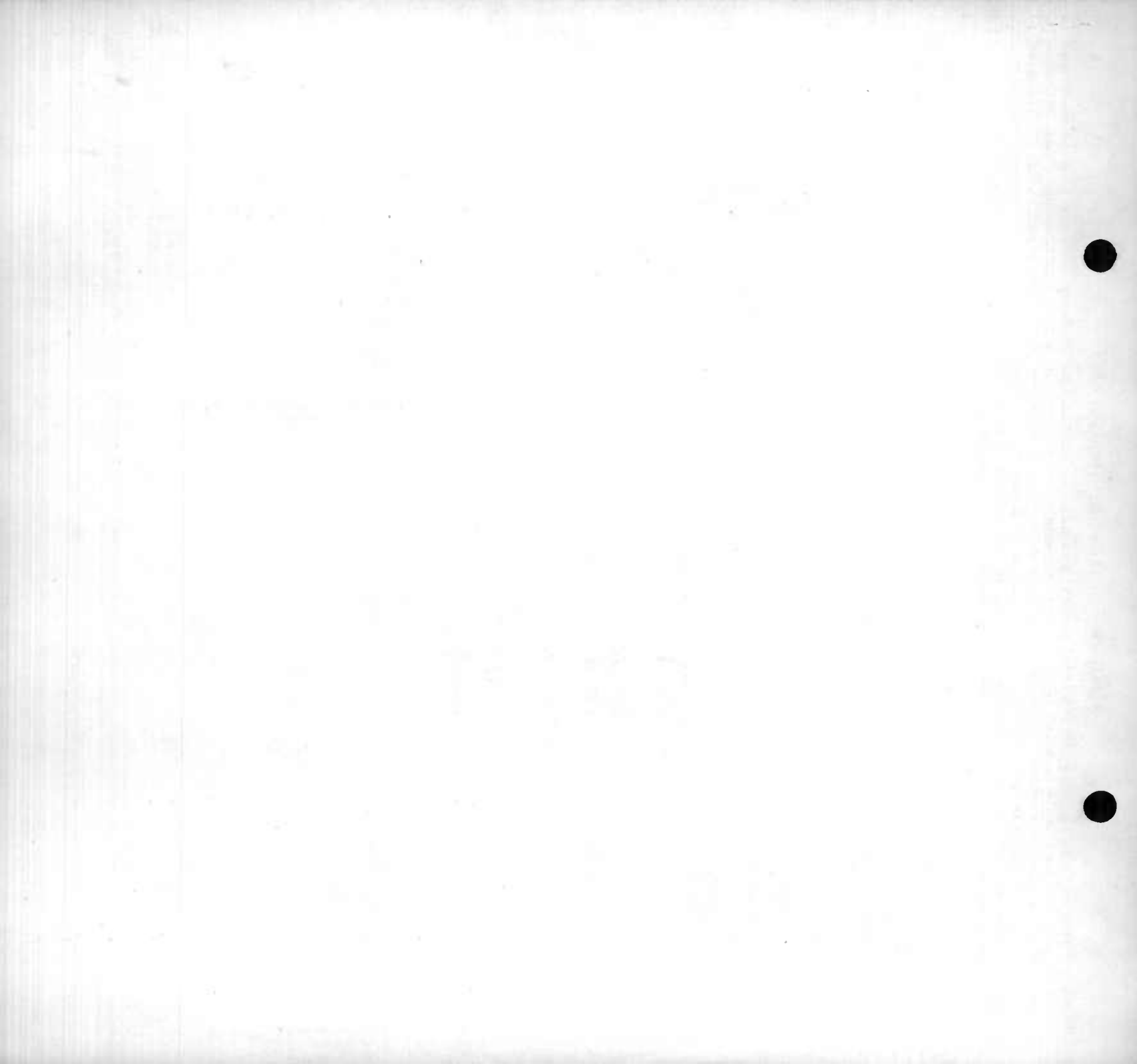


48-21-91 D1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

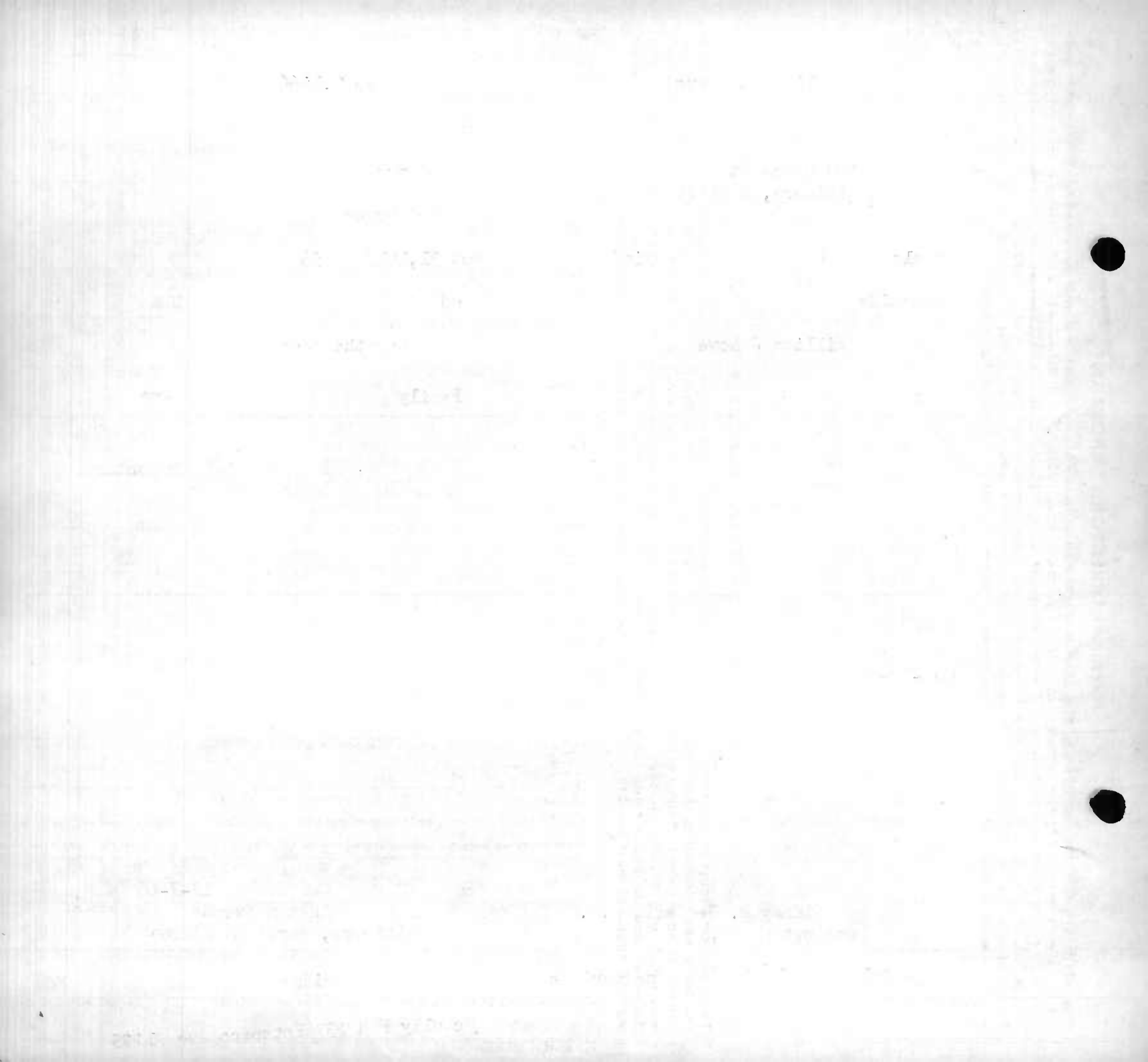
BIRTH NO. 66 12322				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12322	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ANNA LAMBROS</b>				2. DATE AND HOUR OF DEATH <b>7 DECEMBER 1966 5:55 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>26-10 3214 E. Baltimore Street #21224</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>June 9, 1896</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH Baltimore, Maryland #21224</b>			
18. CAUSE OF DEATH <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>DIABETES</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>ARTERIOSCLEROSIS</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <b>53 YRS -</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1 DECEMBER, 1966</b> to <b>7 DECEMBER, 1966</b> , that (I) (we) last saw the deceased alive on <b>7 DECEMBER, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Daniel D. Foote</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>7 DECEMBER, 1966</b>			
23C. PHYSICIAN'S NAME (Type) <b>Daniel D. Foote</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Md. #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Joseph M. Zannino 263 S. Conkling</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12323	
BIRTH NO. 66 12323		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Elizabeth Daus</b>		2. DATE AND HOUR OF DEATH <b>Dec 7, 1966</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4200 Grace Ct Baltimore, Md 21225</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4200 Grace Ct</b>			
5. SEX <b>Female</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct 31, 1910</b>	9. AGE (In years lost birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William J Lowe</b>			14. MOTHER'S MAIDEN NAME <b>Maratha Koch</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>  ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>none</b>		CAUSE OF DEATH (A) <b>Carcinoma of the Colon with generalized abdominal metastases.</b> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
19A. DATE OF OPERATION <b>9-16-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>carcinoma</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 6</b> 19 <b>56</b> to <b>12/7</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 6</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sidney R. Gehlert</b> M.D., Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>12-7-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sidney R. Gehlert, M.D.</b> <b>4700 Pennington Avenue #21226</b> M.D.				23D. ADDRESS <b>4700 Pennington Avenue</b> <b>Baltimore, Maryland 21226</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge</b>	
24D. LOCATION <b>Elkridge</b>		24E. LOCATION <b>Elkridge</b>		24F. LOCATION <b>Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>McCully F H</b> ADDRESS <b>237 Patapsco Ave 21225</b>	

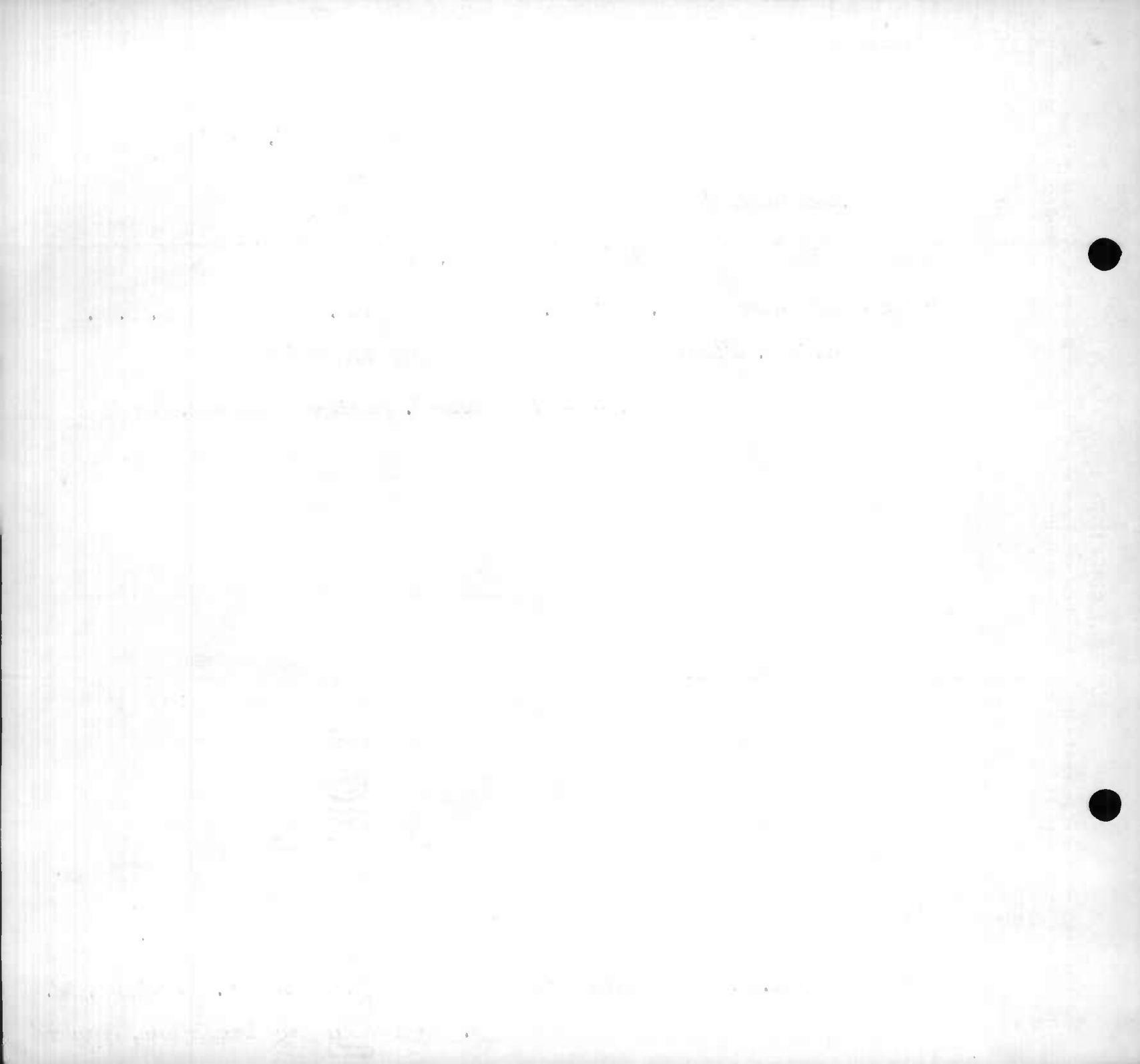




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 12324				
BIRTH NO. 66 12324					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Mrs. Monica Tennison					2. DATE AND HOUR OF DEATH 12.8.66 4:55 (P.M.)				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION  37 Mercy Hospital					A. STATE Maryland				
					B. COUNTY St. Mary's Co.				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
Morganza 68-00					Rural				
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Oct. 30, 1900		9. AGE (in years last birthday) 66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Public Health Nurse		St. Mary's Co.		Mass.			U. S. A.		
13. FATHER'S NAME Dennis J. O'Leary					14. MOTHER'S MAIDEN NAME Lucy Ann Murphy				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 217-36-9418		17. INFORMANT Harry A. Tennison		
					Morganza, Maryland		ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES					INTERVAL BETWEEN ONSET AND DEATH				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					Renal & congestive heart failure 8 yrs				
					G.I. hemorrhage 1 d.				
					Severe Emphysema many yrs.				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
no			no			no		no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
no									
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from Nov 24 1966 to Dec 8 1966, that (I) (we) last saw the deceased alive on Dec 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Nanong Ruang Ruchirama M.D.								23B. DATE SIGNED 12.8.66	
23C. PHYSICIAN'S NAME (Type) NANONG RUANG RUCHIRAMA M.D.								23D. ADDRESS Mercy Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)	
Burial			Dec. 10, 1966		Moreland Park			2901 Taylor Ave. Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
DEC 9 1966			Robert E. Farkas M.D.			W. Clarke Mattingley Leonardtown, Maryland			



66 12325

BALTIMORE CITY HEALTH DEPARTMENT

66 12325

BIRTH NO. 65-21170

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CAROL LYNN TILLERY

2. DATE AND HOUR PRONOUNCED DEAD December 8, 1966 4:40 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

5. STATE Maryland

6. COUNTY Baltimore

7. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

8. STREET ADDRESS (If rural, give location) 114 N. Madera Street

9. SEX Female

10. RACE Negro

11. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never

12. 8. DATE OF BIRTH 8-31-65

13. 9. AGE (in years last birthday) 1

14. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

15. 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

16. 10B. KIND OF BUSINESS OR INDUSTRY none

17. 11. BIRTHPLACE (State or foreign country) Baltimore Md

18. 12. CITIZEN OF WHAT COUNTRY? USA

19. 13. FATHER'S NAME Edward Tillery

20. 14. MOTHER'S MAIDEN NAME Betty Usmon

21. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No

22. 16. SOCIAL SECURITY NO.

23. 17. INFORMANT Betty Tillery

24. ADDRESS same

25. 18. CAUSE OF DEATH

26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

27. (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

28. ANTECEDENT CAUSES

29. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

30. (A) Subendocardial Fibroelastosis.

31. DUE TO

32. (B) DUE TO

33. (C) DUE TO

34. INTERVAL BETWEEN ONSET AND DEATH

35. MEDICAL CERTIFICATION

36. II

37. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

38. 19A. DATE OF OPERATION

39. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

40. 20A. AUTOPSY? (Yes or No) No

41. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

42. 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

43. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

44. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

45. 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

46. 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

47. 21F. HOW DID INJURY OCCUR?

48. 22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

49. ACTUAL SIGNATURE Charles S. Petty M.D.

50. CHIEF MEDICAL EXAMINER

51. ASSISTANT MEDICAL EXAMINER

52. ASSOCIATE MEDICAL EXAMINER

53. DATE SIGNED 12/8/66

54. 23A. BURIAL CREMATION, REMOVAL (Specify) Burial

55. 23B. DATE 12-12-66

56. 23C. NAME of CEMETERY or CREMATORY Mt Auburn Cem

57. 23D. LOCATION (City, town, or county) (State) Baltimore Md

58. 24A. DATE REC'D BY HEALTH DEPT. DEC 9 1966

59. 24B. NAME OF REGISTRAR Robert E. Farley

60. 24C. FUNERAL DIRECTOR Chas. O. Wilson

61. ADDRESS 1000 Crantley Rd

VS 151-REV. 1/1/65

8-21-42

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12-12-42 Peterson's

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12326				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12326	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HELEN Mc MORRIS</b>				2. DATE AND HOUR OF DEATH <b>12/7/66 8<sup>30</sup> PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTO. 42</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 16 28-03</b> D. STREET ADDRESS (If rural, give location) <b>4411 WAKEFIELD RD.</b>			
5. SEX <b>F.</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>11/22/26</b>	9. AGE (In years lost birthday) <b>40</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Perry L. CRAWFORD</b>			14. MOTHER'S MAIDEN NAME <b>Bernice Whiting</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>HOSPITAL CHARGE</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>LEIOMYOSARCOMA WITH WIDESPREAD METASTASIS</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9:05 AM 12/7</b> 19 <b>66</b> to <b>8<sup>30</sup> PM 12/7</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/7</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>S. Frank</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/7/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>SHELDON M. FRANK</b>				23D. ADDRESS M.D. <b>SINAI HOSPITAL OF BALTO.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-10-66</b>		24C. NAME of CEMETERY or CREMATORY <b>McCarhey Cent</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Clayton Wilson</b>			

May 1911  
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May 1911

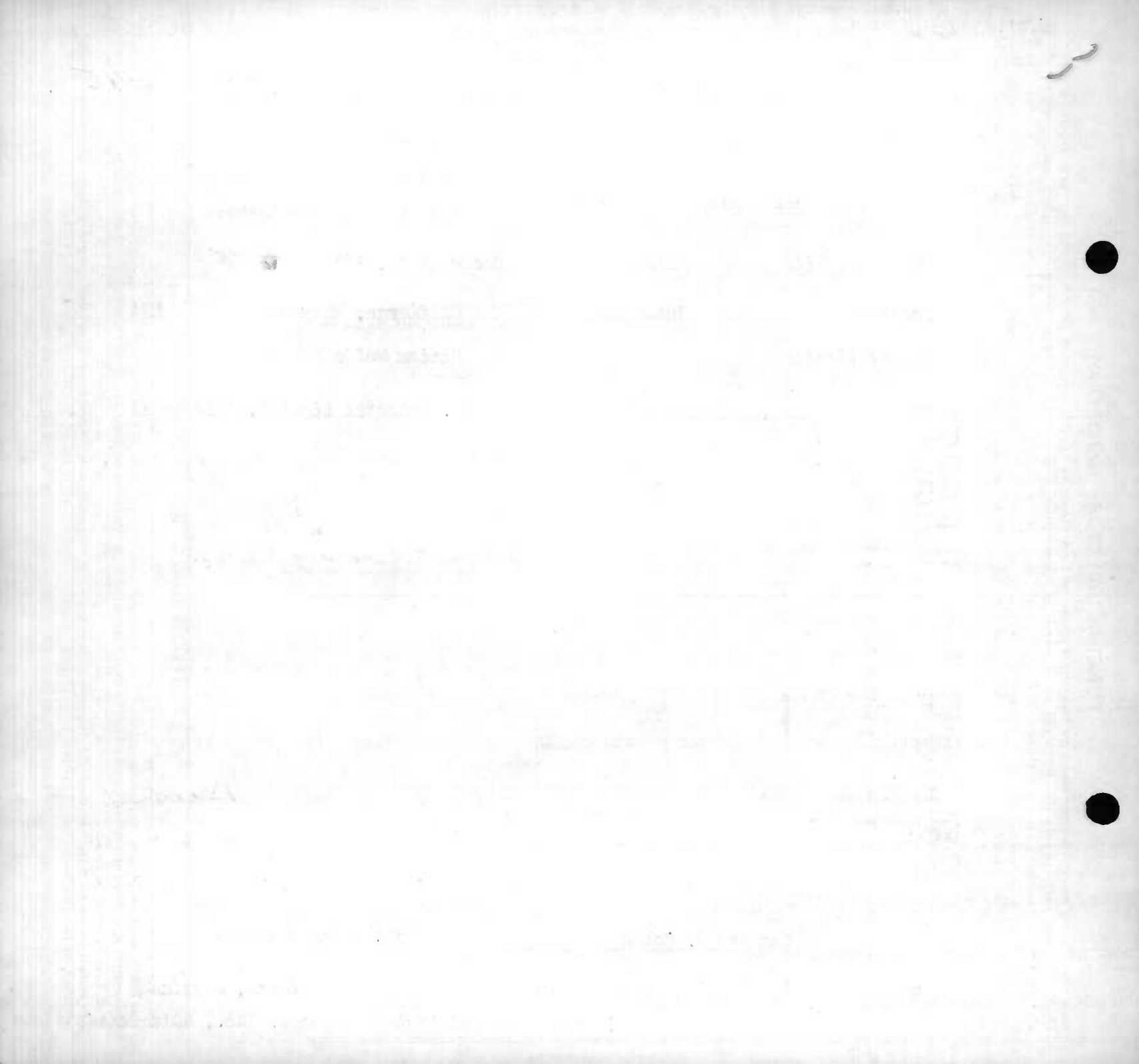
May 1911

May 1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12327</u>	
<b>BIRTH NO.</b> <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>THOMAS LIPNICK</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>December 7, 1966</u>   <u>6:45 P. M.</u>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <u>00</u> <u>6034 GREEN MEADOW PARKWAY</u> (If not in hospital or institution, give street address or location)		<b>4. USUAL RESIDENCE</b> (Where decedent lived. If institution: residence before admission) <b>A. STATE</b> <u>Maryland</u> <b>B. COUNTY</b> <u>Baltimore</u> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <u>Baltimore</u> <b>D. STREET ADDRESS</b> (If rural, give location) <u>6034 Green Meadow Parkway</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED, NEVER MARRIED</b> <u>WIDOWED, DIVORCED (specify)</u> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>December 25, 1890</u>	<b>9. AGE</b> (In years last birthday) <u>75</u> If Under 1 Yr. Months: Days: Hours: Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u>
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Insurance</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Robert Lipnick</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Miriam Wolfe</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>	<b>17. INFORMANT</b> <u>Mrs. Margaret Lipnick, 6034 Green Meadow Pkwy</u> <b>ADDRESS</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>42011</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		<b>CAUSE OF DEATH</b> (A) <u>Acute Coronary Thrombosis</u> DUE TO (B) <u>Chronic Coronary Insuff.</u> DUE TO (C) <u>Last acute Coronary June '63</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1/2 hour.</u>	
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <u>None</u>					
<b>19A. DATE OF OPERATION</b> <input type="checkbox"/>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <input type="checkbox"/>		<b>20A. AUTOPSY?</b> (Yes or No) <u>No</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <input type="checkbox"/>	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour) <input type="checkbox"/>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <input type="checkbox"/>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct. 23</u> <u>1966</u> <b>to</b> <u>December 7</u> <u>1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Oct 23 (Positive)</u> <u>1966</u> <b>and that in (my) (our) opinion death occurred on the date</b> <u>Dec 7 1966</u> <b>and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b> <u>(Emergency) - Dec 7 1966</u>					
<b>23A. SIGNATURE</b> <u>Dr. Bernard J. Cohen</u>				<b>23B. DATE SIGNED</b> <u>12-8-66</u>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <u>Bernard J. Cohen</u>				<b>23D. ADDRESS</b> <u>2708 Whitney Avenue</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>12/9/66</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Petach Tikvah</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 9 1966</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Dr. E. J. ...</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u> <b>ADDRESS</b>			

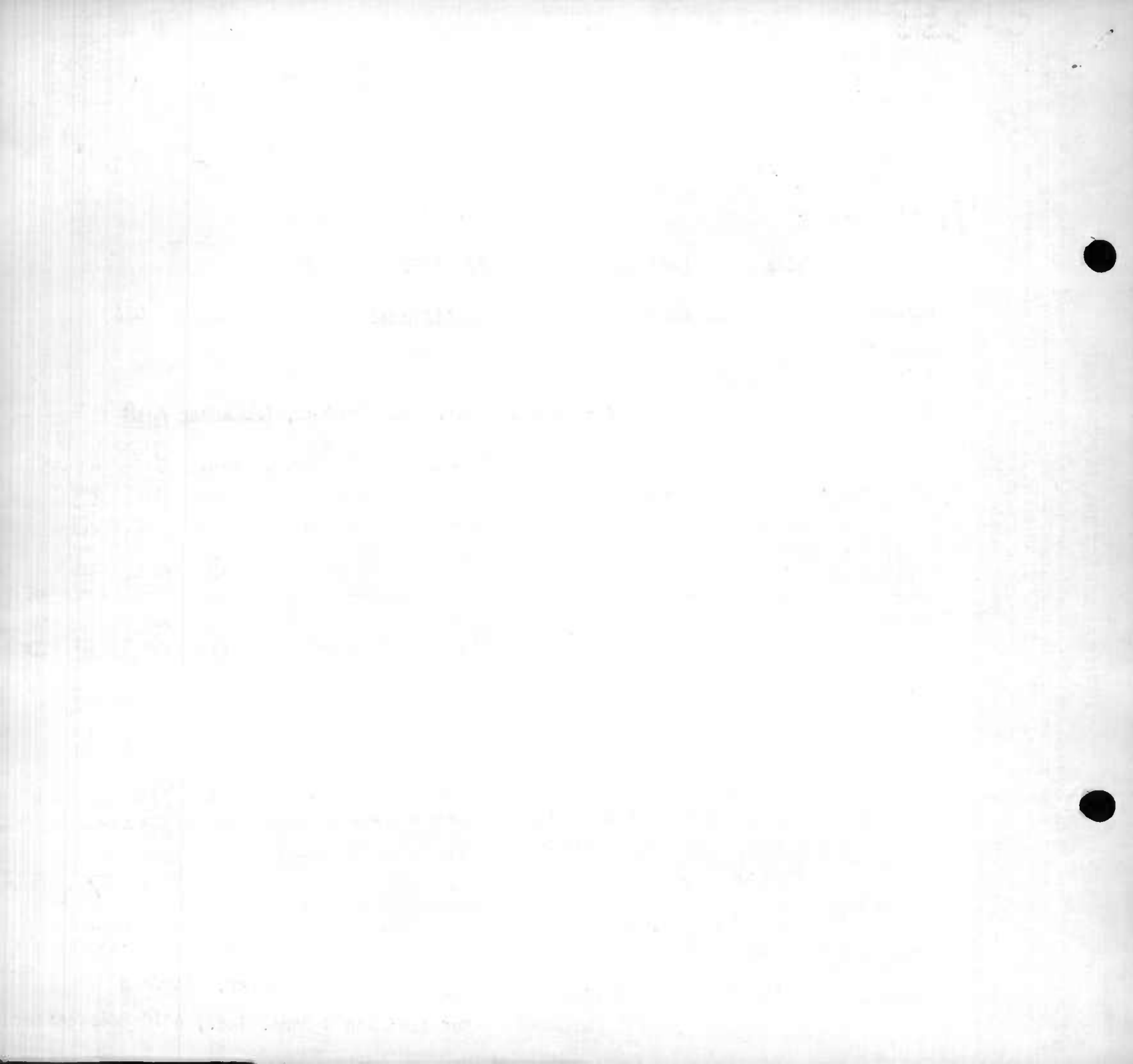




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

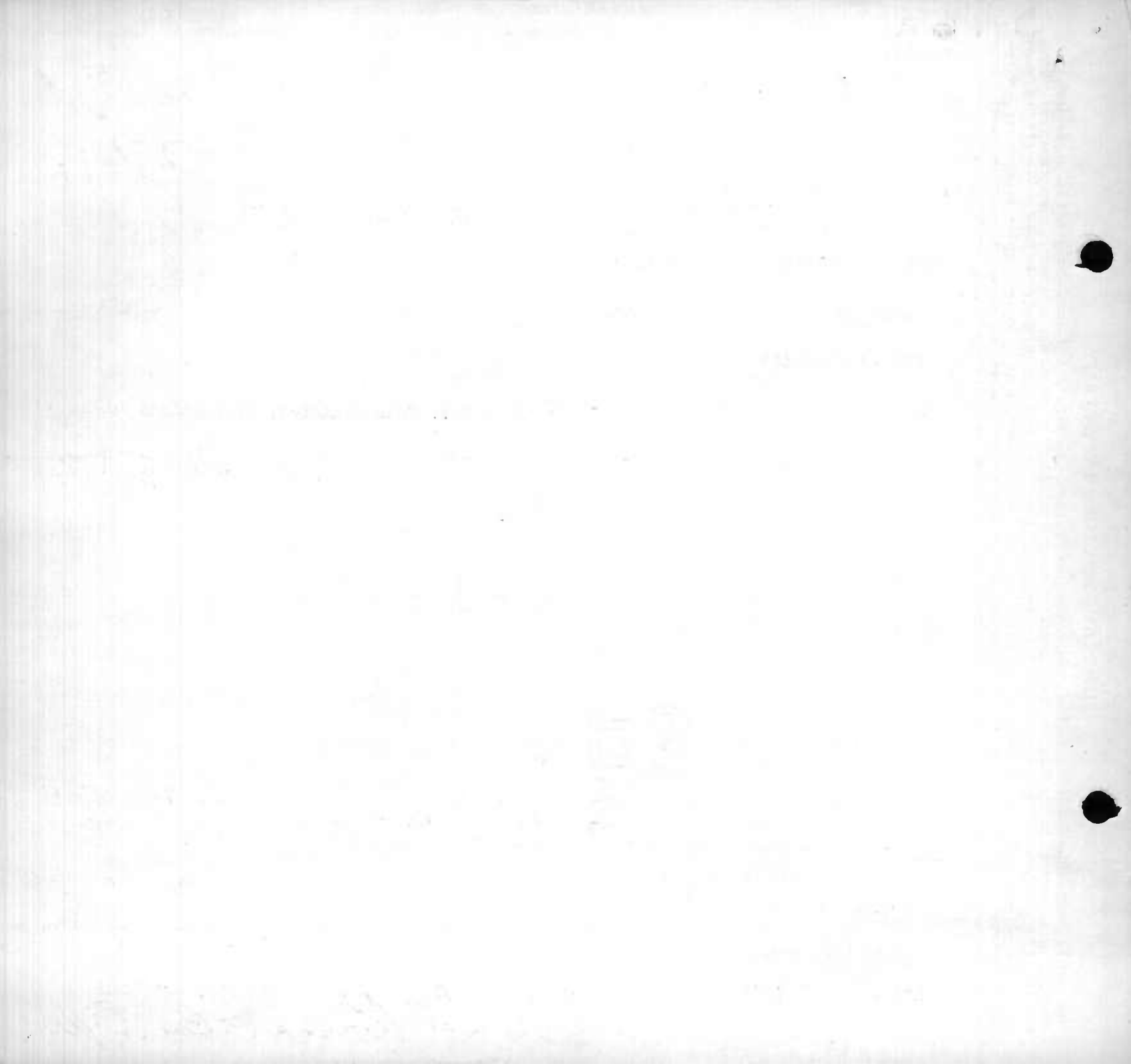
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12328</u>	
BIRTH NO. <u>66 12328</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED <u>Abraham Goodman</u>		2. DATE AND HOUR OF DEATH <u>Dec. 7, 1966 11 A.M.</u>	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Levindale Hebrew Home and Infirmary</u>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		8. DATE OF BIRTH <u>1/3/1878</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		9. AGE (In years last birthday) <u>88</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-4882</u>		17. INFORMANT <u>Mrs. Dara Goodman, Levindale Aged Home</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Gastrointestinal Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>5-6 hours</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>duodenal ulcer</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD</u>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (if this hospital) attended the deceased from <u>5-4-1953</u> to <u>12-7-1966</u> , that (I) (we) lost saw the deceased alive on <u>12-7-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Ruth Willmer</u> M.D.		23B. DATE SIGNED <u>Dec. 7, 1966</u>		23C. PHYSICIAN'S NAME (Type) <u>Ruth Willmer</u>	
23D. ADDRESS <u>Levindale Hebrew Home and Infirmary</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/8/66</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Beth Isaac Adath Israel</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>DEC 9 1966</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc.</u>		25D. ADDRESS <u>6010 Reisterstown</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
66 12329		66 12329			
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Max J. Obertier</b>			2. DATE AND HOUR OF DEATH <b>Dec - 7, 1966 11 45 a.m.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LEVINDALE, HEBREW HOME AND INFIRMARY</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4708 Wilern Avenue #15</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>63</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Morris Obertier</b>			14. MOTHER'S MAIDEN NAME <b>Rose ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-14-1670</b>	17. INFORMANT <b>Mrs. Rose Obertier, 4708 Wilern Avenue #15</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarction, prot.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>6 - 8</b> <b>1964</b> to <b>12 - 7</b> <b>1966</b> , that (1) (we) last saw the deceased alive on <b>12 - 7</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ruth Willner</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Dec - 7, 1966</b>
23C. PHYSICIAN'S NAME (Type) <b>Ruth Willner</b>			23D. ADDRESS <b>Levindale, Hebrew Home and Infirmary Baltimore Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/8/66</b>	24C. NAME of CEMETERY or CREMATORY <b>Mikro Kodesh Beth Israel</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Robert E. Fisher</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12330		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 12330	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>HOLLY, JAMES MATHEWS JR.</b>			2. DATE AND HOUR OF DEATH <b>December 8, 1966</b> <b>9:50P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <b>27 Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.</b> <b>Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>20-02</b> D. STREET ADDRESS (If rural, give location) <b>2667 Edmondson Ave.</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1/9/28</b>	9. AGE (In years lost birthday) <b>38</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Terminal Van Lines</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			13. FATHER'S NAME <b>James M. Holly Sr.</b>		
14. MOTHER'S MAIDEN NAME <b>Rosie Young</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>2/3/51-3/4/55</b>		
16. SOCIAL SECURITY NO. <b>216-22-36-33</b>			17. INFORMANT ADDRESS <b>Hospital Records, Balto., Md. 21218</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hemoptysis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Tuberculosis, Pulmonary, Far-Advanced, Active, Cavitiary</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>12-13-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (x) (this hospital) attended the deceased from <b>December 6, 1966</b> to <b>December 8, 1966</b> , that (x) (we) last saw the deceased alive on <b>December 8, 1966</b> and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>YOUNG E. CHUN</b>				23B. DATE SIGNED <b>12/9/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN</b>				23D. ADDRESS <b>Veterans Hospital, Balto., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-13-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>2700 Edmondson</b>			

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66 12331

BALTIMORE CITY HEALTH DEPARTMENT

66 12331

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE MCCRAY

2. DATE AND HOUR PRONOUNCED DEAD

December 10, 1966 3:08 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1203 Harlem Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

4-22-12

9. AGE (in years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Mingo McCray

14. MOTHER'S MAIDEN NAME

Amanda ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Hattie McCray

ADDRESS

Same

18.

148X-260X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Cachexia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Carcinoma of Pharynx  
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/11/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-15-66

23C. NAME of CEMETERY or CREMATORY

Caryer Mem. PK.

23D. LOCATION

Layrel

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 12 1966

Rudiger E. Breiteneker

Sullivan Funeral Home - N. Arlington Ave

WILLIAM STORRE

W. Storr



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 12332</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 12332</b>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Elizabeth Patzwall</b>			2. DATE AND HOUR OF DEATH <b>12/8/66 7:10 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 1-04</b>			D. STREET ADDRESS (If rural, give location) <b>904 S. B. Inney St.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>2/26/91</b>	9. AGE (In years last birthday) <b>75</b>	10. Under 1 Yr. Months Days   11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>George Wayson</b>			14. MOTHER'S MAIDEN NAME <b>Barbara Wittnauer</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT (Son) ADDRESS <b>Robt. Patzwall 2813 Hudson St. Balto. Md.</b>		
18. <b>42011-260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		CAUSE OF DEATH (A) <b>Congestive heart failure</b> DUE TO (B) <b>Acute Myocardial</b> DUE TO (C) <b>Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>  <b>weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus &amp; Obesity</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>11/30</b> 19 <b>66</b> to <b>12/8</b> 19 <b>66</b> , that <del>we</del> (we) lost her the deceased alive on <b>12/8</b> 19 <b>66</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>the</del> (did) <del>(do)</del> view the body after death.					
23A. SIGNATURE <b>Bernard du Buy</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>12/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Bernard du Buy</b>		23D. ADDRESS <b>Maryland Genl. Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/12/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart of Jesus</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda Inc. 2829 Hudson St. Balto. Md.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12333</u>	
BIRTH NO. <u>66 12333</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Katherine M. Ruth</u>		2. DATE AND HOUR OF DEATH <u>12-6-66</u> <u>11:24 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>Edgemere</u> <u>53-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>2500 S. Snyder Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED <u>Divorced</u>	8. DATE OF BIRTH <u>5-19-92</u>	9. AGE (In years last birthday) <u>74</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Lentz, Christian</u>		14. MOTHER'S MAIDEN NAME <u>Hoehn, Elizabeth</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-9498</u>		17. INFORMANT ADDRESS <u>Hospital chart</u>	
18. <u>570.31</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Myocardial Infarction</u>		<u>24 hr.</u>	
ANTECEDENT CAUSES		(B) <u>Operative hypotension</u>		<u>30 hr.</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Sigmoid Volvulus</u>	
19A. DATE OF OPERATION <u>12-5-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Sigmoid Volvulus</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-2-66</u> to <u>12-6-66</u> that (I) (we) last saw the deceased alive on <u>12-6-66</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter MacMurray</u>				23B. DATE SIGNED <u>12/6/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Peter MacMurray</u>				23D. ADDRESS <u>University Hospital, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/9/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John J. Duda 7922 Wise Ave. Dundalk, Md.</u>			

Katherine M. Kelly

University Hospital

F M Overed

Homestead

Lents

No.

200-2000 Hospital chart

Operative Information  
Preoperative Information

Signs of Voluntary

12-2-66 Signs of Voluntary

Dr. [Signature]

12-2-66

12-2-66

12-2-66

10/10/66

Department of Medicine, University of Maryland

University of Maryland

John A. [Signature]

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66 12334

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12334

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LARRY STEWART

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966 12:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1242 E. Monument Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug 15, 1951

9. AGE (In years  
lost birthday)

15

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Stewart

14. MOTHER'S MAIDEN NAME

Dorothy Sanders

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

?

17. INFORMANT

ADDRESS

Mrs. Dorothy Stewart 1242 E. Monument St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of Head  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

In Front of 816 N. Bond Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
12 3 '66 11:58P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Was shot in head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-8-66

23C. NAME of CEMETERY or CREMATORY

Mr. Calvary Cemetery

23D. LOCATION

(City, town, or county)

A.A. Co., Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 12 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Marshall Jones, Jr. 1735 Harford Ave.

ADDRESS

Aug 12, 1931

Ensign

Baltimore, Maryland

Room

Room

Photography

James Stewart

Mrs. Dorothy Stewart 1212 E. Lombard

no

A.A. Co., Maryland

Mr. Calvary Company

12-2-31

Ensign

Marshall Jones, Jr. 1712 Eastern Ave.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 66 12335</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>Registered No. 66 12335</span> </div>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MARY M. EBEL</b>		2. DATE AND HOUR OF DEATH <b>DEC. 6, 1966, 1:15 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>35 CHURCH HOME AND HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>26-07</b> D. STREET ADDRESS (If rural, give location) <b>838 S. PONCA ST. #21224</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-17-97</b>
9. AGE (In years last birthday) <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND, HARTFORD, Co.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		13. FATHER'S NAME <b>GEORGE IRELAND</b>	
14. MOTHER'S MAIDEN NAME <b>REBECCA GREEN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>216-07-7670A</b>		17. INFORMANT <b>HENRY C. EBEL</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC HRT. DISEASE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>NOV. 16 1966</b> to <b>DEC. 6 1966</b> , that (I) (we) last saw the deceased alive on <b>DEC. 6 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>7-2-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. A. E. SAPPINGTON JR.</b>		23D. ADDRESS <b>Church Ave &amp; Annapolis</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-10-66</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MEADOWRIDGE CENETRY</b>		24D. LOCATION (City, town, or county) (State) <b>WASH. BLVD. &amp; DORSEY RD. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Juler</b>		25D. ADDRESS <b>6224 EASTERN AVE. BALTO., 21224, MD.</b>	



CHURCH HOME AND HOSPITAL

RECEIVED

HOUSE WIFE

GEORGE IRELAND

REBECCA GREEN

MARYLAND

9-17-97

838 S. BRUCE ST.

BALTIMORE

MARYLAND

ALTEMSCHERSTIC HAT SHANE

DEC 10

DEC 10

DEC 10

DEC 10

DEC 10

DEC 10



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 12336		CERTIFICATE OF DEATH		Registered No. 66 12336	
1. NAME OF DECEASED (Type or Print) <u>Smith, John Lewis</u>				2. DATE AND HOUR OF DEATH <u>2:20 Am. Dec 9, 1966</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balt. Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>OWINGS Mills</u> D. STREET ADDRESS (If rural, give location) <u>38 Church Road 21117</u>					
5. SEX <u>M</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>6-30-08</u>		9. AGE (In years last birthday) <u>58</u>		If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scout Executive - Boy Scouts of America Iowa</u>				11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>J. William Smith</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Withmore</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>089-26-7617</u>		17. INFORMANT <u>Mrs Grace Smith</u>		ADDRESS <u>see (Carstensen) Same as Above</u>	
18. <u>292.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Aplastic Anemia</u>				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 28</u> 19 <u>66</u> to <u>Dec 9</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2:25 Am. Dec 9</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>A. W. Song</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Dec 9, 1966</u>			
23C. PHYSICIAN'S NAME (Type) <u>SANG WON SONG,</u>				23D. ADDRESS M.D. <u>THE UNION MEMORIAL HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/12/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>David Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pocomoke 8, Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Loring Byers - 8728 Liberty Rd</u>					

The Green Mountain Hospital

28. 92-85-1

~~Dr. William Smith~~ Dr. William Smith

Dr. William Smith

Dr. William Smith

Dr. William Smith

Dr. William Smith

Dr. William Smith

Dr. William Smith

Dr. William Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12337	
BIRTH NO. 66 12337				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Turney, Maud B</u>			2. DATE AND HOUR OF DEATH <u>12/7/66</u> <u>4:20</u> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hospital</u> <u>46</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>13-08</u> D. STREET ADDRESS (If rural, give location) <u>4204 - Falls Road.</u>		
5. SEX <u>Fe</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8/31/84</u>	9. AGE (In years lost birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Drug Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
13. FATHER'S NAME <u>Coles</u>			14. MOTHER'S MAIDEN NAME <u>—</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 01 4480 D</u>		17. INFORMANT <u>Paul B Turney Sr</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4204 - Falls Rd Baltimore</u>		CAUSE OF DEATH (A) <u>Probable Acute Coronary Thrombosis</u> DUE TO (B) <u>Hypertensive Arteriosclerotic Cardiovascular Disease.</u> DUE TO (C) <u>Disease.</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 5, 1966</u> to <u>December 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>December 7, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert C. Blackmon</u>				23B. DATE SIGNED <u>12/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert C. Blackmon</u>				23D. ADDRESS <u>Lutheran Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>New Central Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fadden</u>		25C. FUNERAL DIRECTOR <u>Burgess Funeral Home</u>		25D. ADDRESS <u>3631 Falls Rd Baltimore</u>	

Wilted  
Dead, blig.  
Culcs

herb

Pachy

Paul Blaney

1/10

Handwritten notes at the bottom left, including "Paul Blaney" and "1/10".

Handwritten notes at the bottom right, including "1/10".

S-432

66 12338

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12338

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

VICTOR STEWART SLUTZKIN

2. DATE AND HOUR PRONOUNCED DEAD

December 6, 1966 6:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3502 W. Stratmore Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3502 W. Stratmore Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb 2, 1950

9. AGE (In years last birthday)

16

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Boy

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto, Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George

14. MOTHER'S MAIDEN NAME

Leona

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown (If yes, give war or dates of service))

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

George Slutzkin 3502 W. Stratmore Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hanging  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes - Partial

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3502 W. Stratmore Avenue

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

12 6 '66 1:00

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hung self

22.

I certify that I held an Inquiry ☐ Inspection ☐ P. Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/7/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12/8/1966

23C. NAME of CEMETERY or CREMATORY

Hebrew Friendship

23D. LOCATION (City, town, or county) (State)

Balto Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 12 1966

24B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

Sylvan S. Lewis & Son, Inc

ADDRESS

3319 Olympic Ave

1950

1951

1952

1953

1954

1955

1956

1957 12/2/57 1958 1/1/58 1959 2/1/59 1960 3/1/60 1961 4/1/61 1962 5/1/62 1963 6/1/63 1964 7/1/64 1965 8/1/65 1966 9/1/66 1967 10/1/67 1968 11/1/68 1969 12/1/69 1970 1/1/70 1971 2/1/71 1972 3/1/72 1973 4/1/73 1974 5/1/74 1975 6/1/75 1976 7/1/76 1977 8/1/77 1978 9/1/78 1979 10/1/79 1980 11/1/80 1981 12/1/81 1982 1/1/82 1983 2/1/83 1984 3/1/84 1985 4/1/85 1986 5/1/86 1987 6/1/87 1988 7/1/88 1989 8/1/89 1990 9/1/90 1991 10/1/91 1992 11/1/92 1993 12/1/93 1994 1/1/94 1995 2/1/95 1996 3/1/96 1997 4/1/97 1998 5/1/98 1999 6/1/99 2000 7/1/00 2001 8/1/01 2002 9/1/02 2003 10/1/03 2004 11/1/04 2005 12/1/05 2006 1/1/06 2007 2/1/07 2008 3/1/08 2009 4/1/09 2010 5/1/10 2011 6/1/11 2012 7/1/12 2013 8/1/13 2014 9/1/14 2015 10/1/15 2016 11/1/16 2017 12/1/17 2018 1/1/18 2019 2/1/19 2020 3/1/20 2021 4/1/21 2022 5/1/22 2023 6/1/23 2024 7/1/24 2025 8/1/25 2026 9/1/26 2027 10/1/27 2028 11/1/28 2029 12/1/29 2030 1/1/30 2031 2/1/31 2032 3/1/32 2033 4/1/33 2034 5/1/34 2035 6/1/35 2036 7/1/36 2037 8/1/37 2038 9/1/38 2039 10/1/39 2040 11/1/40 2041 12/1/41 2042 1/1/42 2043 2/1/43 2044 3/1/44 2045 4/1/45 2046 5/1/46 2047 6/1/47 2048 7/1/48 2049 8/1/49 2050 9/1/50 2051 10/1/51 2052 11/1/52 2053 12/1/53 2054 1/1/54 2055 2/1/55 2056 3/1/56 2057 4/1/57 2058 5/1/58 2059 6/1/59 2060 7/1/60 2061 8/1/61 2062 9/1/62 2063 10/1/63 2064 11/1/64 2065 12/1/65 2066 1/1/66 2067 2/1/67 2068 3/1/68 2069 4/1/69 2070 5/1/70 2071 6/1/71 2072 7/1/72 2073 8/1/73 2074 9/1/74 2075 10/1/75 2076 11/1/76 2077 12/1/77 2078 1/1/78 2079 2/1/79 2080 3/1/80 2081 4/1/81 2082 5/1/82 2083 6/1/83 2084 7/1/84 2085 8/1/85 2086 9/1/86 2087 10/1/87 2088 11/1/88 2089 12/1/89 2090 1/1/90 2091 2/1/91 2092 3/1/92 2093 4/1/93 2094 5/1/94 2095 6/1/95 2096 7/1/96 2097 8/1/97 2098 9/1/98 2099 10/1/99 2100 11/1/00 2101 12/1/01 2102 1/1/02 2103 2/1/03 2104 3/1/04 2105 4/1/05 2106 5/1/06 2107 6/1/07 2108 7/1/08 2109 8/1/09 2110 9/1/10 2111 10/1/11 2112 11/1/12 2113 12/1/13 2114 1/1/14 2115 2/1/15 2116 3/1/16 2117 4/1/17 2118 5/1/18 2119 6/1/19 2120 7/1/20 2121 8/1/21 2122 9/1/22 2123 10/1/23 2124 11/1/24 2125 12/1/25 2126 1/1/26 2127 2/1/27 2128 3/1/28 2129 4/1/29 2130 5/1/30 2131 6/1/31 2132 7/1/32 2133 8/1/33 2134 9/1/34 2135 10/1/35 2136 11/1/36 2137 12/1/37 2138 1/1/38 2139 2/1/39 2140 3/1/40 2141 4/1/41 2142 5/1/42 2143 6/1/43 2144 7/1/44 2145 8/1/45 2146 9/1/46 2147 10/1/47 2148 11/1/48 2149 12/1/49 2150 1/1/50 2151 2/1/51 2152 3/1/52 2153 4/1/53 2154 5/1/54 2155 6/1/55 2156 7/1/56 2157 8/1/57 2158 9/1/58 2159 10/1/59 2160 11/1/60 2161 12/1/61 2162 1/1/62 2163 2/1/63 2164 3/1/64 2165 4/1/65 2166 5/1/66 2167 6/1/67 2168 7/1/68 2169 8/1/69 2170 9/1/70 2171 10/1/71 2172 11/1/72 2173 12/1/73 2174 1/1/74 2175 2/1/75 2176 3/1/76 2177 4/1/77 2178 5/1/78 2179 6/1/79 2180 7/1/80 2181 8/1/81 2182 9/1/82 2183 10/1/83 2184 11/1/84 2185 12/1/85 2186 1/1/86 2187 2/1/87 2188 3/1/88 2189 4/1/89 2190 5/1/90 2191 6/1/91 2192 7/1/92 2193 8/1/93 2194 9/1/94 2195 10/1/95 2196 11/1/96 2197 12/1/97 2198 1/1/98 2199 2/1/99 2200 3/1/00 2201 4/1/01 2202 5/1/02 2203 6/1/03 2204 7/1/04 2205 8/1/05 2206 9/1/06 2207 10/1/07 2208 11/1/08 2209 12/1/09 2210 1/1/10 2211 2/1/11 2212 3/1/12 2213 4/1/13 2214 5/1/14 2215 6/1/15 2216 7/1/16 2217 8/1/17 2218 9/1/18 2219 10/1/19 2220 11/1/20 2221 12/1/21 2222 1/1/22 2223 2/1/23 2224 3/1/24 2225 4/1/25 2226 5/1/26 2227 6/1/27 2228 7/1/28 2229 8/1/29 2230 9/1/30 2231 10/1/31 2232 11/1/32 2233 12/1/33 2234 1/1/34 2235 2/1/35 2236 3/1/36 2237 4/1/37 2238 5/1/38 2239 6/1/39 2240 7/1/40 2241 8/1/41 2242 9/1/42 2243 10/1/43 2244 11/1/44 2245 12/1/45 2246 1/1/46 2247 2/1/47 2248 3/1/48 2249 4/1/49 2250 5/1/50 2251 6/1/51 2252 7/1/52 2253 8/1/53 2254 9/1/54 2255 10/1/55 2256 11/1/56 2257 12/1/57 2258 1/1/58 2259 2/1/59 2260 3/1/60 2261 4/1/61 2262 5/1/62 2263 6/1/63 2264 7/1/64 2265 8/1/65 2266 9/1/66 2267 10/1/67 2268 11/1/68 2269 12/1/69 2270 1/1/70 2271 2/1/71 2272 3/1/72 2273 4/1/73 2274 5/1/74 2275 6/1/75 2276 7/1/76 2277 8/1/77 2278 9/1/78 2279 10/1/79 2280 11/1/80 2281 12/1/81 2282 1/1/82 2283 2/1/83 2284 3/1/84 2285 4/1/85 2286 5/1/86 2287 6/1/87 2288 7/1/88 2289 8/1/89 2290 9/1/90 2291 10/1/91 2292 11/1/92 2293 12/1/93 2294 1/1/94 2295 2/1/95 2296 3/1/96 2297 4/1/97 2298 5/1/98 2299 6/1/99 2300 7/1/00 2301 8/1/01 2302 9/1/02 2303 10/1/03 2304 11/1/04 2305 12/1/05 2306 1/1/06 2307 2/1/07 2308 3/1/08 2309 4/1/09 2310 5/1/10 2311 6/1/11 2312 7/1/12 2313 8/1/13 2314 9/1/14 2315 10/1/15 2316 11/1/16 2317 12/1/17 2318 1/1/18 2319 2/1/19 2320 3/1/20 2321 4/1/21 2322 5/1/22 2323 6/1/23 2324 7/1/24 2325 8/1/25 2326 9/1/26 2327 10/1/27 2328 11/1/28 2329 12/1/29 2330 1/1/30 2331 2/1/31 2332 3/1/32 2333 4/1/33 2334 5/1/34 2335 6/1/35 2336 7/1/36 2337 8/1/37 2338 9/1/38 2339 10/1/39 2340 11/1/40 2341 12/1/41 2342 1/1/42 2343 2/1/43 2344 3/1/44 2345 4/1/45 2346 5/1/46 2347 6/1/47 2348 7/1/48 2349 8/1/49 2350 9/1/50 2351 10/1/51 2352 11/1/52 2353 12/1/53 2354 1/1/54 2355 2/1/55 2356 3/1/56 2357 4/1/57 2358 5/1/58 2359 6/1/59 2360 7/1/60 2361 8/1/61 2362 9/1/62 2363 10/1/63 2364 11/1/64 2365 12/1/65 2366 1/1/66 2367 2/1/67 2368 3/1/68 2369 4/1/69 2370 5/1/70 2371 6/1/71 2372 7/1/72 2373 8/1/73 2374 9/1/74 2375 10/1/75 2376 11/1/76 2377 12/1/77 2378 1/1/78 2379 2/1/79 2380 3/1/80 2381 4/1/81 2382 5/1/82 2383 6/1/83 2384 7/1/84 2385 8/1/85 2386 9/1/86 2387 10/1/87 2388 11/1/88 2389 12/1/89 2390 1/1/90 2391 2/1/91 2392 3/1/92 2393 4/1/93 2394 5/1/94 2395 6/1/95 2396 7/1/96 2397 8/1/97 2398 9/1/98 2399 10/1/99 2400 11/1/00 2401 12/1/01 2402 1/1/02 2403 2/1/03 2404 3/1/04 2405 4/1/05 2406 5/1/06 2407 6/1/07 2408 7/1/08 2409 8/1/09 2410 9/1/10 2411 10/1/11 2412 11/1/12 2413 12/1/13 2414 1/1/14 2415 2/1/15 2416 3/1/16 2417 4/1/17 2418 5/1/18 2419 6/1/19 2420 7/1/20 2421 8/1/21 2422 9/1/22 2423 10/1/23 2424 11/1/24 2425 12/1/25 2426 1/1/26 2427 2/1/27 2428 3/1/28 2429 4/1/29 2430 5/1/30 2431 6/1/31 2432 7/1/32 2433 8/1/33 2434 9/1/34 2435 10/1/35 2436 11/1/36 2437 12/1/37 2438 1/1/38 2439 2/1/39 2440 3/1/40 2441 4/1/41 2442 5/1/42 2443 6/1/43 2444 7/1/44 2445 8/1/45 2446 9/1/46 2447 10/1/47 2448 11/1/48 2449 12/1/49 2450 1/1/50 2451 2/1/51 2452 3/1/52 2453 4/1/53 2454 5/1/54 2455 6/1/55 2456 7/1/56 2457 8/1/57 2458 9/1/58 2459 10/1/59 2460 11/1/60 2461 12/1/61 2462 1/1/62 2463 2/1/63 2464 3/1/64 2465 4/1/65 2466 5/1/66 2467 6/1/67 2468 7/1/68 2469 8/1/69 2470 9/1/70 2471 10/1/71 2472 11/1/72 2473 12/1/73 2474 1/1/74 2475 2/1/75 2476 3/1/76 2477 4/1/77 2478 5/1/78 2479 6/1/79 2480 7/1/80 2481 8/1/81 2482 9/1/82 2483 10/1/83 2484 11/1/84 2485 12/1/85 2486 1/1/86 2487 2/1/87 2488 3/1/88 2489 4/1/89 2490 5/1/90 2491 6/1/91 2492 7/1/92 2493 8/1/93 2494 9/1/94 2495 10/1/95 2496 11/1/96 2497 12/1/97 2498 1/1/98 2499 2/1/99 2500 3/1/00 2501 4/1/01 2502 5/1/02 2503 6/1/03 2504 7/1/04 2505 8/1/05 2506 9/1/06 2507 10/1/07 2508 11/1/08 2509 12/1/09 2510 1/1/10 2511 2/1/11 2512 3/1/12 2513 4/1/13 2514 5/1/14 2515 6/1/15 2516 7/1/16 2517 8/1/17 2518 9/1/18 2519 10/1/19 2520 11/1/20 2521 12/1/21 2522 1/1/22 2523 2/1/23 2524 3/1/24 2525 4/1/25 2526 5/1/26 2527 6/1/27 2528 7/1/28 2529 8/1/29 2530 9/1/30 2531 10/1/31 2532 11/1/32 2533 12/1/33 2534 1/1/34 2535 2/1/35 2536 3/1/36 2537 4/1/37 2538 5/1/38 2539 6/1/39 2540 7/1/40 2541 8/1/41 2542 9/1/42 2543 10/1/43 2544 11/1/44 2545 12/1/45 2546 1/1/46 2547 2/1/47 2548 3/1/48 2549 4/1/49 2550 5/1/50 2551 6/1/51 2552 7/1/52 2553 8/1/53 2554 9/1/54 2555 10/1/55 2556 11/1/56 2557 12/1/57 2558 1/1/58 2559 2/1/59 2560 3/1/60 2561 4/1/61 2562 5/1/62 2563 6/1/63 2564 7/1/64 2565 8/1/65 2566 9/1/66 2567 10/1/67 2568 11/1/68 2569 12/1/69 2570 1/1/70 2571 2/1/71 2572 3/1/72 2573 4/1/73 2574 5/1/74 2575 6/1/75 2576 7/1/76 2577 8/1/77 2578 9/1/78 2579 10/1/79 2580 11/1/80 2581 12/1/81 2582 1/1/82 2583 2/1/83 2584 3/1/84 2585 4/1/85 2586 5/1/86 2587 6/1/87 2588 7/1/88 2589 8/1/89 2590 9/1/90 2591 10/1/91 2592 11/1/92 2593 12/1/93 2594 1/1/94 2595 2/1/95 2596 3/1/96 2597 4/1/97 2598 5/1/98 2599 6/1/99 2600 7/1/00 2601 8/1/01 2602 9/1/02 2603 10/1/03 2604 11/1/04 2605 12/1/05 2606 1/1/06 2607 2/1/07 2608 3/1/08 2609 4/1/09 2610 5/1/10 2611 6/1/11 2612 7/1/12 2613 8/1/13 2614 9/1/14 2615 10/1/15 2616 11/1/16 2617 12/1/17 2618 1/1/18 2619 2/1/19 2620 3/1/20 2621 4/1/21 2622 5/1/22 2623 6/1/23 2624 7/1/24 2625 8/1/25 2626 9/1/26 2627 10/1/27 2628 11/1/28 2629 12/1/29 2630 1/1/30 2631 2/1/31 2632 3/1/32 2633 4/1/33 2634 5/1/34 2635 6/1/35 2636 7/1/36 2637 8/1/37 2638 9/1/38 2639 10/1/39 2640 11/1/40 2641 12/1/41 2642 1/1/42 2643 2/1/43 2644 3/1/44 2645 4/1/45 2646 5/1/46 2647 6/1/47 2648 7/1/48 2649 8/1/49 2650 9/1/50 2651 10/1/51 2652 11/1/52 2653 12/1/53 2654 1/1/54 2655 2/1/55 2656 3/1/56 2657 4/1/57 2658 5/1/58 2659 6/1/59 2660 7/1/60 2661 8/1/61 2662 9/1/62 2663 10/1/63 2664 11/1/64 2665 12/1/65 2666 1/1/66 2667 2/1/67 2668 3/1/68 2669 4/1/69 2670 5/1/70 2671 6/1/71 2672 7/1/72 2673 8/1/73 2674 9/1/74 2675 10/1/75 2676 11/1/76 2677 12/1/77 2678 1/1/78 2679 2/1/79 2680 3/1/80 2681 4/1/81 2682 5/1/82 2683 6/1/83 2684 7/1/84 2685 8/1/85 2686 9/1/86 2687 10/1/87 2688 11/1/88 2689 12/1/89 2690 1/1/90 2691 2/1/91 2692 3/1/92 2693 4/1/93 2694 5/1/94 2695 6/1/95 2696 7/1/96 2697 8/1/97 2698 9/1/98 2699 10/1/99 2700 11/1/00 2701 12/1/01 2702 1/1/02 2703 2/1/03 2704 3/1/04 2705 4/1/05 2706 5/1/06 2707 6/1/07 2708 7/1/08 2709 8/1/09 2710 9/1/10 2711 10/1/11 2712 11/1/12 2713 12/1/13 2714 1/1/14 2715 2/1/15 2716 3/1/16 2717 4/1/17 2718 5/1/18 2719 6/1/19 2720 7/1/20 2721 8/1/21 2722 9/1/22 2723 10/1/23 2724 11/1/24 2725 12/1/25 2726 1/1/26 2727 2/1/27 2728 3/1/28 2729 4/1/29 2730 5/1/30 2731 6/1/31 2732 7/1/32 2733 8/1/33 2734 9/1/34 2735 10/1/35 2736 11/1/36 2737 12/1/37 2738 1/1/38 2739 2/1/39 2740 3/1/40 2741 4/1/41 2742 5/1/42 2743 6/1/43 2744 7/1/44 2745 8/1/45 2746 9/1/46 2747 10/1/47 2748 11/1/48 2749 12/1/49 2750 1/1/50 2751 2/1/51 2752 3/1/52 2753 4/1/53 2754 5/1/54 2755 6/1/55 2756 7/1/56 2757 8/1/57 2758 9/1/58 2759 10/1/59 2760 11/1/60 2761 12/1/61 2762 1/1/62 2763 2/1/63 2764 3/1/64 2765 4/1/65 2766 5/1/66 2767 6/1/67 2768 7/1/68 2769 8/1/69 2770 9/1/70 2771 10/1/71 2772 11/1/72 2773 12/1/73 2774 1/1/74 2775 2/1/75 2776 3/1/76 2777 4/1/77 2778 5/1/78 2779 6/1/79 2780 7/1/80 2781 8/1/81 2782 9/1/82 2783 10/1/83 2784 11/1/84 2785 12/1/85 2786 1/1/86 2787 2/1/87 2788 3/1/88 2789 4/1/89 2790 5/1/90 2791 6/1/91 2792 7/1/92 2793 8/1/93 2794 9/1/94 2795 10/1/95 2796 11/1/96 2797 12/1/97 2798 1/1/98 2799 2/1/99 2800 3/1/00 2801 4/1/01 2802 5/1/02 2803 6/1/03 2804 7/1/04 2805 8/1/05 2806 9/1/06 2807 10/1/07 2808 11/1/08 2809 12/1/09 2810 1/1/10 2811 2/1/11 2812 3/1/12 2813 4/1/13 2814 5/1/14 2815 6/1/15 2816 7/1/16 2817 8/1/17 2818 9/1/18 2819 10/1/19 2820 11/1/20 2821 12/1/21 2822 1/1/22 2823 2/1/23 2824 3/1/24 2825 4/1/25 2826 5/1/26 2827 6/1/27 2828 7/1/28 2829 8/1/29 2830 9/1/30 2831 10/1/31 2832 11/1/32 2833 12/1/33 2834 1/1/34 2835 2/1/35 2836 3/1/36 2837 4/1/37 2838 5/1/38 2839 6/1/39 2840 7/1/40 2841 8/1/41 2842 9/1/42 2843 10/1/43 2844 11/1/44 2845 12/1/45 2846 1/1/46 2847 2/1/47 2848 3/1/48 2849 4/1/49 2850 5/1/50 2851 6/1/51 2852 7/1/52 2853 8/1/53 2854 9/1/54 2855 10/1/55 2856 11/1/56 2857 12/1/57 2858 1/1/58 2859 2/1/59 2860 3/1/60 2861 4/1/61 2862 5/1/62 2863 6/1/63 2864 7/1/64 2865 8/1/65 2866 9/1/66 2867 10/1/67 2868 11/1/68 2869 12/1/69 2870 1/1/70 2871 2/1/71 2872 3/1/72 2873 4/1/73 2874 5/1/74 2875 6/1/75 2876 7/1/76 2877 8/1/77 2878 9/1/78 2879 10/1/79 2880 11/1/80 2881 12/1/81 2882 1/1/82 2883 2/1/83 2884 3/1/84 2885 4/1/85 2886 5/1/86 2887 6/1/87 2888 7/1/88 2889 8/1/89 2890 9/1/90 2891 10/1/91 2892 11/1/92 2893 12/1/93 2894 1/1/94 2895 2/1/95 2896 3/1/96 2897 4/1/97 2898 5/1/98 2899 6/1/99 2900 7/1/00 2901 8/1/01 2902 9/1/02 2903 10/1/03 2904 11/1/04 2905 12/1/05 2906 1/1/06 2907 2/1/07 2908 3/1/08 2909 4/1/09 2910 5/1/10 2911 6/1/11 2912 7/1/12 2913 8/1/13 2914 9/1/14 2915 10/1/15 2916 11/1/16 2917 12/1/17 2918 1/1/18 2919 2/1/19 2920 3/1/20 2921 4/1/21 2922 5/1/22 2923 6/1/23 2924 7/1/24 2925 8/1/25 2926 9/1/26 2927 10/1/27 2928 11/1/28 2929 12/1/29 2930 1/1/30 2931 2/1/31 2932 3/1/32 2933 4/1/33 2934 5/1/34 2935 6/1/35 2936 7/1/36 2937 8/1/37 2938 9/1/38 2939 10/1/39 2940 11/1/40 2941 12/1/41 2942 1/1/42 2943 2/1/43 2944 3

66 12339

BALTIMORE CITY HEALTH DEPARTMENT

66 12339

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM C. BLOOM

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1966 4:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44 Union Memorial Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6004 Hunt Club Lane

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Sept. 6, 1902

9. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Owner-Bloom Electrical Contractors

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Bloom

14. MOTHER'S MAIDEN NAME

Margaret Lentz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

213109196

17. INFORMANT

Evelyn G. Bloom

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic  
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED20A. AUTOPSY? (Yes or No)  
No20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

23B. DATE

12-12-66

23C. NAME OF CEMETERY or CREMATORY

Moreland Mem. Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 12 1966

24B. NAME OF REGISTRAR

Robert E. Felt

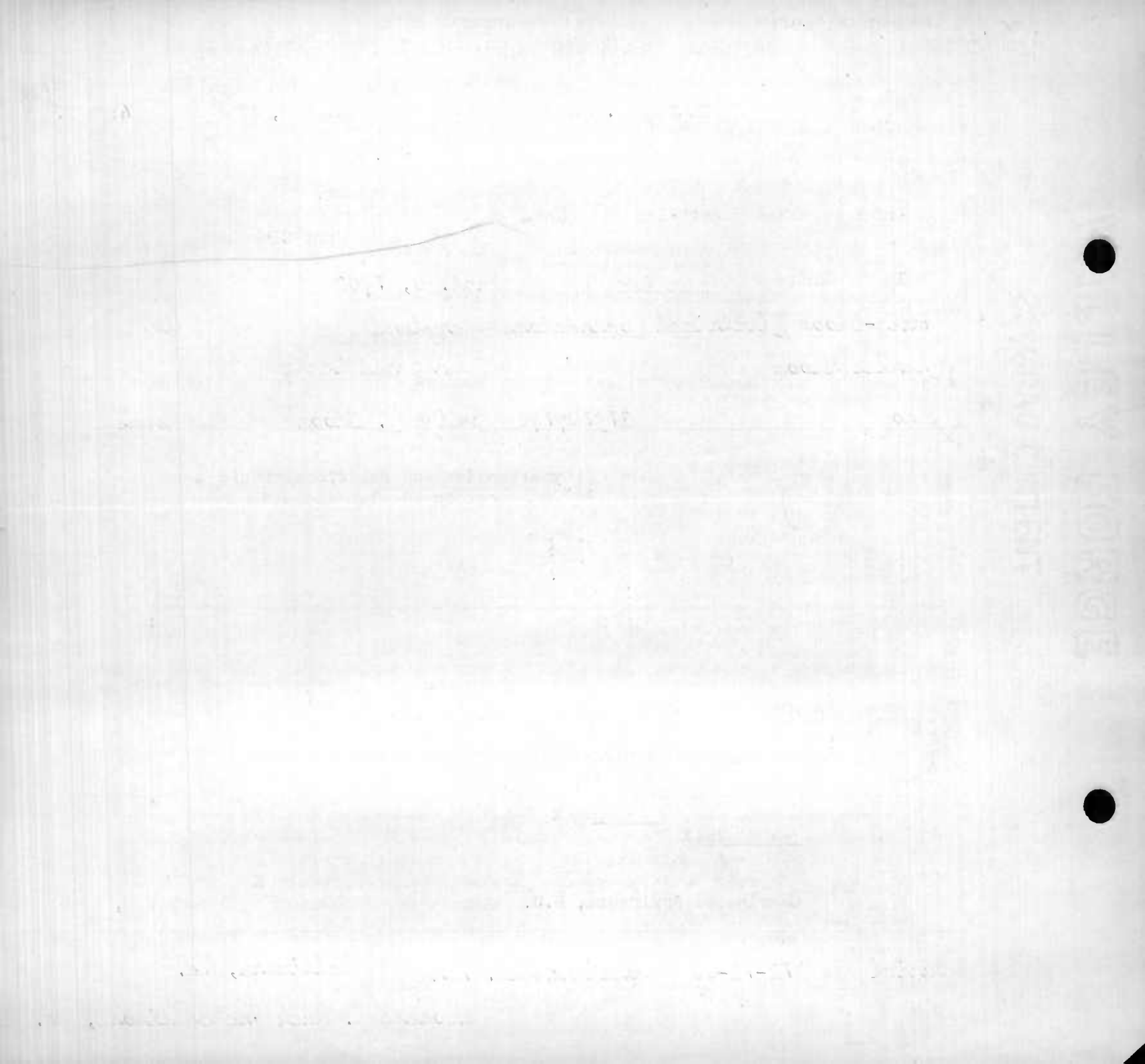
24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc Baltimore, Md.

ADDRESS

FILED FORGE

NEW CONTENT

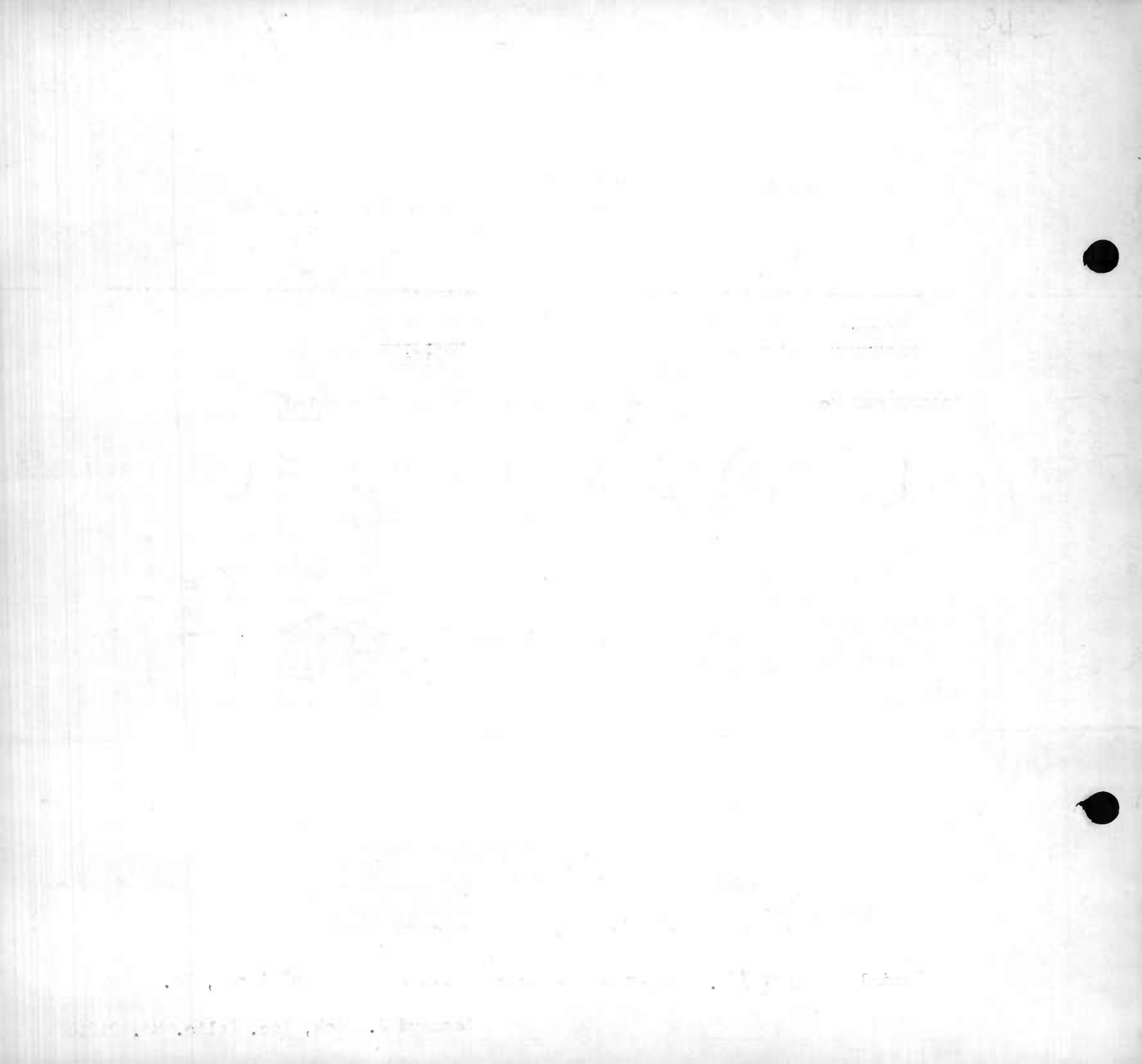




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 12340					CERTIFICATE OF DEATH					Registered No. 66 12340									
1. NAME OF DECEASED (Type or Print) <i>Guy Richard Bedell</i>										2. DATE AND HOUR OF DEATH <i>Dec. 8, 1966</i> <span style="float: right;"><i>1:20p.m.</i></span>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>91 Montebello State Hospital</i>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balt. Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <span style="float: right;"><i>33-00</i></span> D. STREET ADDRESS (If rural, give location) <i>2618 Wycliffe Rd.</i>									
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)			8. DATE OF BIRTH <i>9-26-96</i>		9. AGE (In years lost birthday) <i>70</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bartender</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>New York</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>						
13. FATHER'S NAME <i>Edward Bedell</i>					14. MOTHER'S MAIDEN NAME <i>Nellie Musson</i>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>212-01-5757A</i>			17. INFORMANT <i>Hospital chart</i>			ADDRESS								
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) <i>Cancer of prostate gland with metastases -</i> (B) <i>Unknown cause -</i> (C)					INTERVAL BETWEEN ONSET AND DEATH <i>approx. 3 months</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Docubitus ulcer of right hip</i>															<i>6 days.</i>				
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>No</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1, 1966</i> to <i>Dec. 8, 1966</i> , that (I) (we) lost saw the deceased alive on <i>Dec. 8, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>C. J. Pellerano</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED <i>Dec. 8, 1966</i>									
23C. PHYSICIAN'S NAME (Type) <i>Cesar J. Pellerano</i> M.D.					23D. ADDRESS <i>Montebello Hosp.</i>														
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>12/12/66.</i>		24C. NAME of CEMETERY or CREMATORY <i>Moreland Memorial Cemetery</i>					24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>									
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1966</i>					25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>					25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>					ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				Registered No. <span style="border: 1px solid black; padding: 2px;">X</span>	
BIRTH NO. <span style="font-size: 1.2em;">66 12341</span>		DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12-8-66 10<sup>15</sup> AM.</span>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BROWN, JESSE TELISON</span>		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Union Memorial Hospital</span>		A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE Co.</span>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>			
		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">8604 HARFORD Rd.</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <span style="font-size: 1.2em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3/1/94</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">72</span>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Watchman</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">United States</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">James Francis Brown</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">FANNIE E. Stevens</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">214-01-5979</span>		17. INFORMANT <span style="font-size: 1.2em;">William E Brown</span>	
18. CAUSE OF DEATH		ADDRESS <span style="font-size: 1.2em;">7010 ARDEN AVE BALTIMORE, Md.</span>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Lung Abscess 2° to common 1 lung</span>		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12-4</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">12-8</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12-8</span> 19 <span style="font-size: 1.2em;">66</span> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">John R. Vaughan, Jr.</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">12-8-66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JOHN R. VAUGHAN, JR.</span>		23D. ADDRESS M.D. <span style="font-size: 1.2em;">THE UNION MEMORIAL HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12/12/66.</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Moreland Memorial Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 12 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck, Inc. Balto. Md. 21214</span>	

Maryland  
 800 Maryland St.  
 3/1/24  
 Maryland  
 James E. Stevens

Union Memorial Hospital  
 Male White  
 3/1/24  
 James Francis Brown

James E. Stevens  
 3/1/24  
 Maryland

Yes

J. R. Kraft  
 15-2  
 15-2  
 15-2  
 15-2

THE UNITED STATES

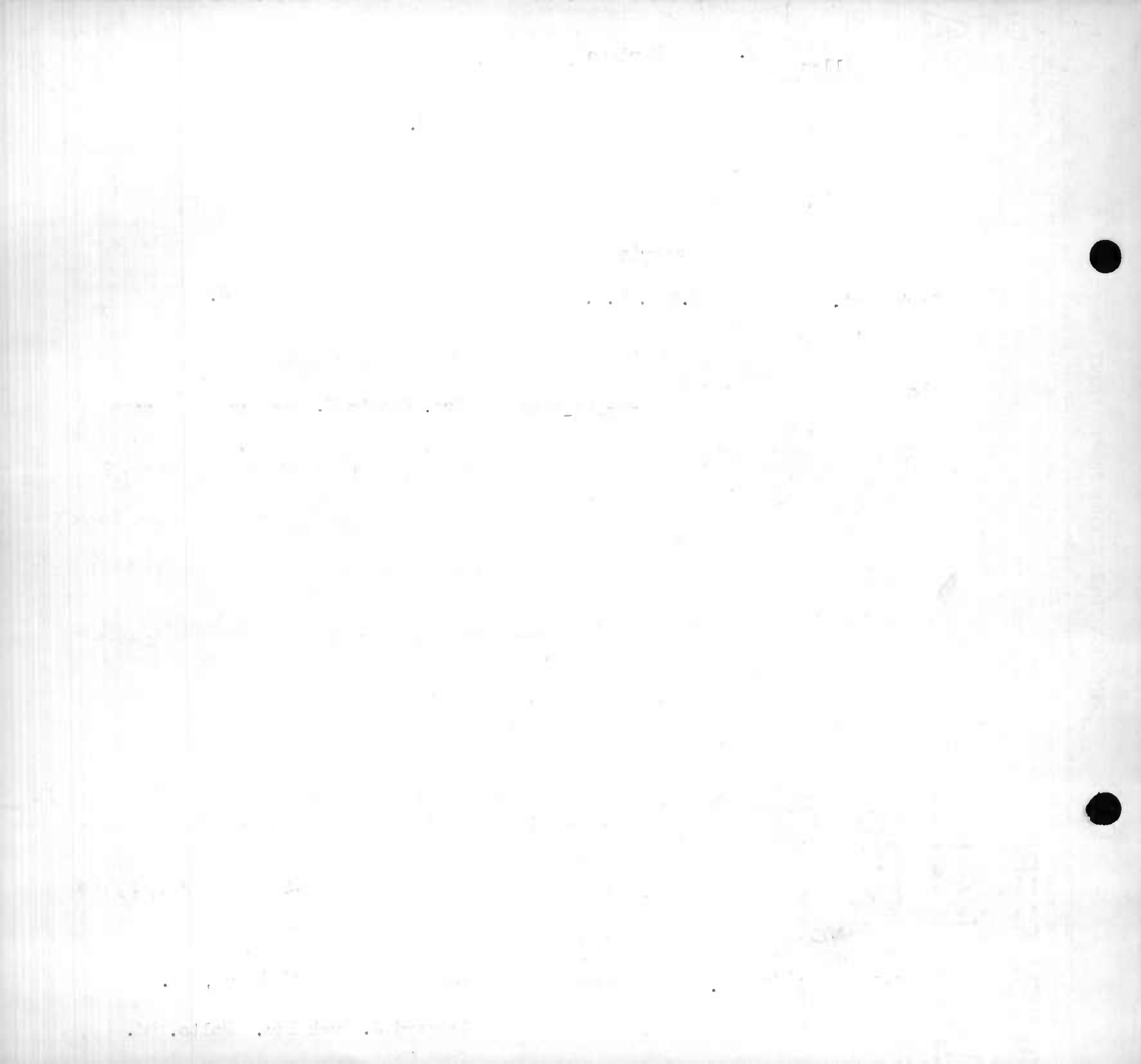
JOHN A. WICK

15-2

15-2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12342	
CERTIFICATE OF DEATH					
BIRTH NO. 66 12342		M.E. CASE NO. R. Hartman		1. NAME OF DECEASED (Type or Print) <del>Allen</del> R. Hartman	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY	
37 Mercy Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		27-03	
		2705 Halcyon Ave.			
		D. STREET ADDRESS (If rural, give location)		Baltimore, Md.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1-19-98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Ret.		10B. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Hartman		14. MOTHER'S MAIDEN NAME Mary Scheffer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-05-3092		17. INFORMANT Mrs. Bessie C. Hartman ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Cardiac insufficiency		days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause, (A) stating the UNDERLYING CONDITION last.		(B) Myocardial Infarction		2 weeks	
		(C) ASCVD, ASUD		years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus		years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (This hospital) attended the deceased from Nov. 22, 1966 to Dec. 8, 1966, that (1) (we) last saw the deceased alive on Dec. 8, 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard D. Shuger M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 12/8/66	
23C. PHYSICIAN'S NAME (Type) Richard David Shuger M.D.				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/66.		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
				24D. LOCATION (City, town, or county) Baltimore, Md. (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. Balto. Md. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 12343		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12343	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) JAMES FRANCIS Lubey		
2. DATE AND HOUR OF DEATH DEC. 8 1966 1 5:30 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2632 ST. BENEDICT ST.			A. STATE MARYLAND B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			D. STREET ADDRESS (If rural, give location) 2632 ST. BENEDICT ST.		
5. SEX MALE	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Oct. 25 1897	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY UTILITIES	11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Lubey			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No NONE		16. SOCIAL SECURITY NO. 050-03-7478	17. INFORMANT Beatha Lubey 2632 ST. BENEDICT ST		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) Hypertensive Cardiovascular D. (B) Coronary Occlusion (C) INTERVAL BETWEEN ONSET AND DEATH 2 1/2		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 6 1966 to Nov 1 1966, that (I) (we) last saw the deceased alive on Nov 1 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Glassman			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Dec 9-66
23C. PHYSICIAN'S NAME (Type) HARRY GLASSMAN			23D. ADDRESS 712 W. Fayette		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-12-66	24C. NAME OF CEMETERY or CREMATORY Church of the Brethren Longgreen Md		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1966		25B. NAME OF REGISTRAR R. B. E. Talley		25C. FUNERAL DIRECTOR G. L. Schwab Funeral Home 2101 Federal Ave	





1  
P-63 66 12344

BALTIMORE CITY HEALTH DEPARTMENT

66 12344

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ADELLE

PORTER

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1966

1:20 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4205 Pimlico Road

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Sep 3, 1939

9. AGE (In years  
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

330X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Massive Subarachnoid Hemorrhage  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Rupture of Congenital Aneurysm of  
Circle of Willis.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/12/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Glen Burne Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 12 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

John T. Carroll 1712 W. North Ave

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. <u>66-12345</u>					Registered No. <u>66-12345</u>				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>VALCOURT, MARY JOE</b>					2. DATE AND HOUR OF DEATH <b>12/9/66 1:15P</b> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b>					A. STATE <b>MARYLAND</b> B. COUNTY <b>Howard Co.</b>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ELKRIDGE 63-00</b>				
D. STREET ADDRESS (If rural, give location) <b>6503 TIMBERVIEW DRIVE</b>									
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>6-10-65</b>	9. AGE (In years lost birthday) <b>1 1/2</b>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>JOSEPH VALCOURT</b>					14. MOTHER'S MAIDEN NAME <b>MARY (SMITH) VALCOURT</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>HOSP. SLIP/ST. AGNES HOSPITAL</b>				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <i>Marsine G.I. bleeding</i> (B) <i>Gastro-enteritis</i> (C) <i>Severe anemia</i>				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (the undersigned) attended the deceased from <b>12/9/66 9:30A</b> to <b>DEC. 9, 1966 1:15P</b> and that (I) (we) last saw the deceased alive on <b>DECEMBER 9, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Reynaldo O. Guzman</i>					23B. DATE SIGNED <b>12/9/66</b>				
23C. PHYSICIAN'S NAME (Type) <b>REYNALDO O. GUZMAN</b>					23D. ADDRESS <b>ST. Agnes Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/11/66</b>		24C. NAME of CEMETERY or CREMATORY <b>ST. AUGUSTINES CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>ELKRIDGE, HOWARD CO., MD.</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD</b>		25D. ADDRESS <b>4107 WILKENS AVE. 21229</b>			

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BALTIMORE CITY HEALTH DEPARTMENT

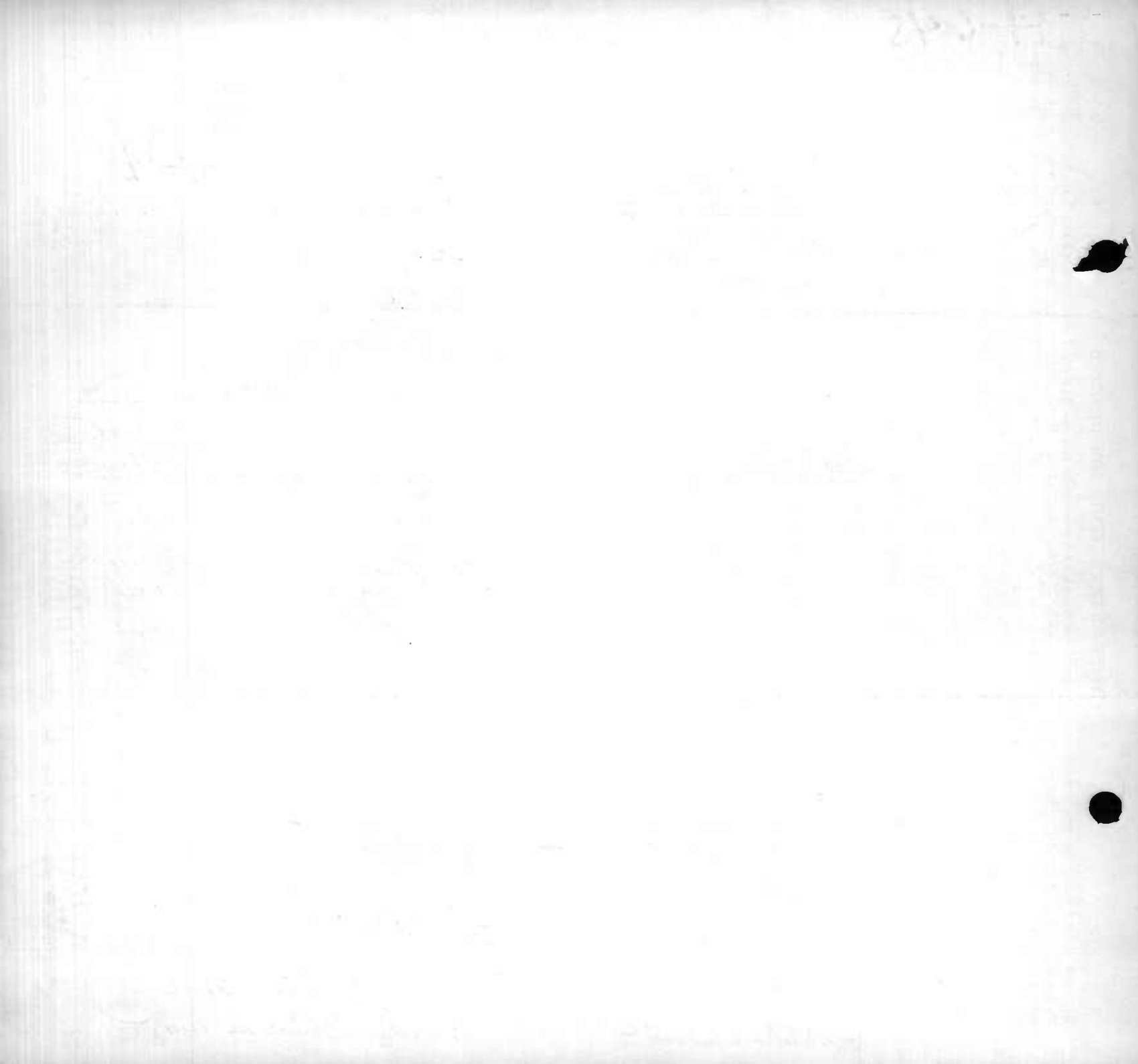
## CERTIFICATE OF DEATH

Registered No. 66 12346

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

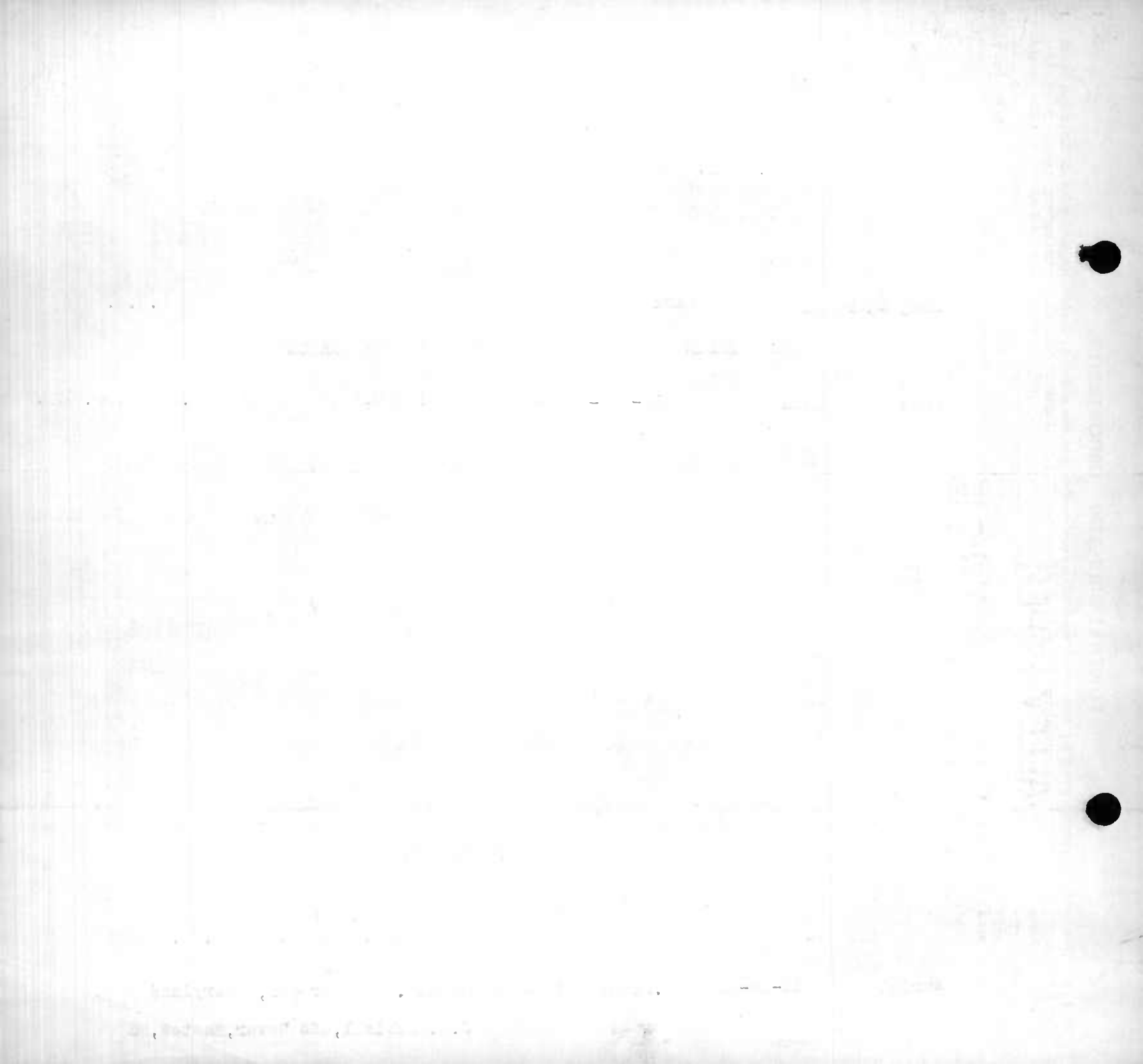
FUNERAL DIRECTOR: IMPORTANT

M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Wallace Harlin</i>		2. DATE AND HOUR OF DEATH <i>11-25-66</i>   <i>9 15</i> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31</i> <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE MARYLAND 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>17 TALBOTT STREET</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>7-6-01</b>	9. AGE (In years lost birthday) <b>65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
13. FATHER'S NAME <b>JAMES</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS BCH</b> ADDRESS <b>4940 EASTERN AVENUE</b>	
18. <i>141.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <i>Septicemia</i> DUE TO (B) <i>Broncho-pneumonia</i> DUE TO (C) <i>Aspiration Pneumonia</i> (D) <i>Squamous Cell CA of Tongue</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>5 days</i> <i>2 weeks</i> <i>14 mos.</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pulmonary Emphysema</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>5-10</i> 19 <i>66</i> to <i>11-25</i> 19 <i>66</i> , that (we) last saw the deceased alive on <i>11-25</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A.J. Spear</i>				23B. DATE SIGNED <i>11-25-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>A.J. Spear</i>				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE MARYLAND 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-9-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Sacred Heart</i>	
24D. LOCATION <i>Balto, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1966</i>		24F. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
24G. FUNERAL DIRECTOR <i>Walter Dabrowski</i>		24H. ADDRESS <i>1005 Dundalk Ave.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12347	
36 66 12347				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Harry Pinder				2. DATE AND HOUR OF DEATH 12-7-66 6:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 17-03	
D. STREET ADDRESS (If rural, give location) 1122 MYRTLE AVENUE 21201					
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/20/06	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME LOUIS PINDER				14. MOTHER'S MAIDEN NAME CHARLOTTE GRACE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None 217- 09- 7346		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave. Balto, Md. 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHF (A) DUE TO Rheumatic Heart Disease (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 2mo Indeterminate					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Jaundice 3 weeks					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11-18-66 to 12-7-66, that (I) (we) last saw the deceased alive on 12-6-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David J. Mishelevich M.D.				23B. DATE SIGNED 12-7-66	
23C. PHYSICIAN'S NAME (Type) DAVID J. MISHELEVICH				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTO. MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-1966		24C. NAME OF CEMETERY OR CREMATORY St. James Method Church Cem.	
24D. LOCATION Sherwood, Maryland		24E. DATE REC'D BY HEALTH DEPT. DEC 12 1966		24F. NAME OF REGISTRAR R. E. E. Farkas	
24G. FUNERAL DIRECTOR J. B. Dashiell, 426 Dever, Easton, MD		24H. ADDRESS			

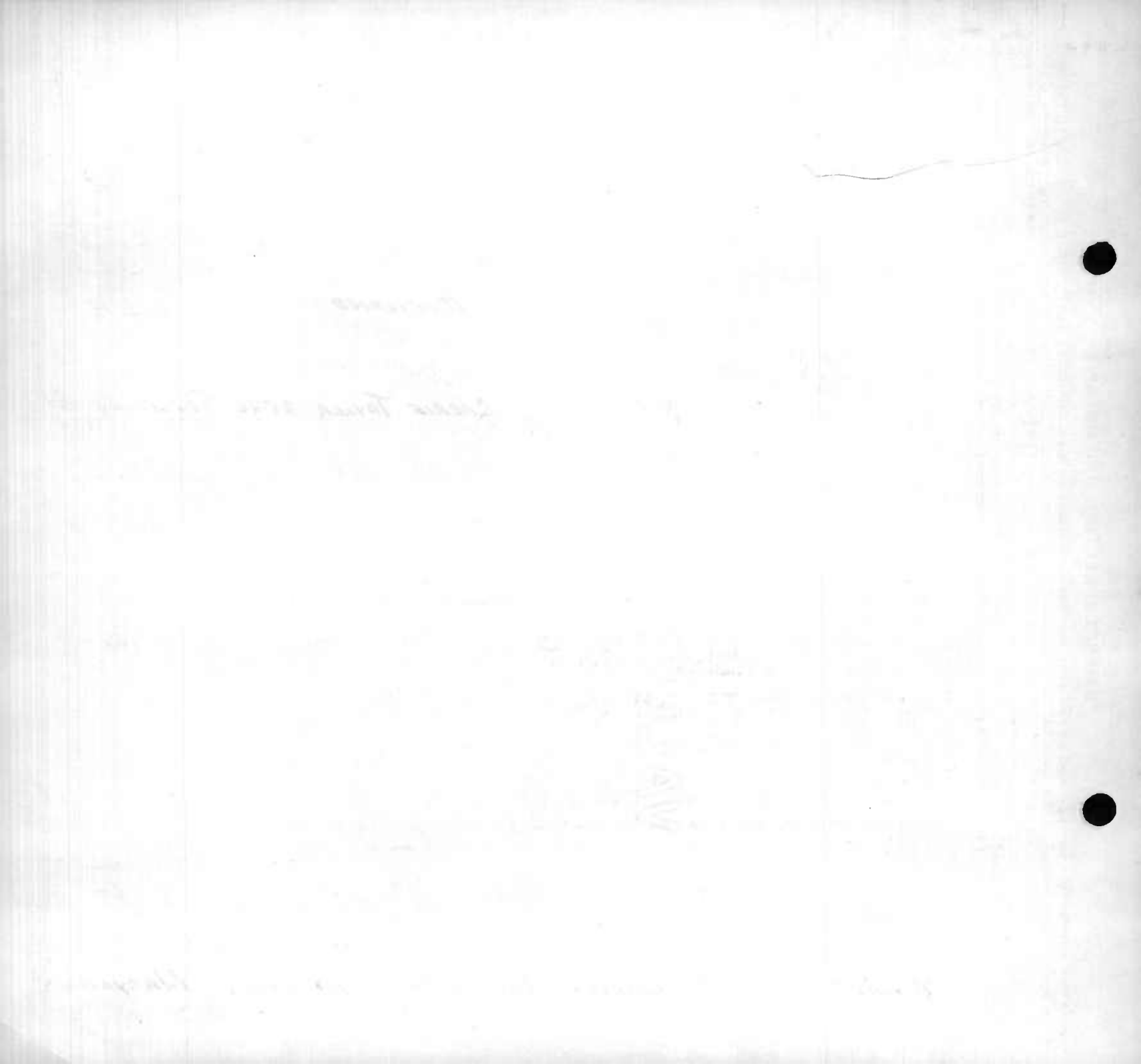




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 12348				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12348	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Cora Lee		9 Dec 66 11:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
90 Fayette Convalescent Home 1105 E Fayette St 21202				Md Bait		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
D. STREET ADDRESS (If rural, give location)				Bait 21216		15 06	
2826 Presbury St				B. DATE OF BIRTH		9. AGE (In years last birthday)	
5. SEX Female				8 Feb '92		74	
6. RACE Col.				7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Robert Smith				Annie Butler		16. SOCIAL SECURITY NO.	
17. INFORMANT				ADDRESS		18. 443 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
CARRIE TAYLOR 2826 PRESBURY ST.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		1 mo	
ANTECEDENT CAUSES				(B) DUE TO		several yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				entwist / healed fracture / cloughed		no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 5 Aug 1966 to 9 Dec 1966 that (I) (we) last saw the deceased alive on 9 Dec 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
J. Hulla				23C. PHYSICIAN'S NAME (Type)		9 Dec 66	
J. Hulla				23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
2114 E. Fayette St 21201				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
12-15-66				CARVER MEM. PH.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 15 1966				Robert E. Jackson		George A. Nelson 1348 N. Calhoun St	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12349		BALTIMORE CITY HEALTH DEPARTMENT	
M.E. CASE NO.		Registered No. 66 12349	
1. NAME OF DECEASED (Type or Print) <i>Sadie E Saunders</i>		2. DATE AND HOUR OF DEATH <i>10 Dec 1966 1 30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224</i>		A. STATE <i>MARYLAND</i> B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>		D. STREET ADDRESS (If rural, give location) <i>1526 N. CAREY ST. #21217</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>1-9-10</i>
9. AGE (In years last birthday) <i>56</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Albert Saunders</i>		14. MOTHER'S MAIDEN NAME <i>Martha</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS <i>RECORDS-BCH-4940 EASTERN AVE. #21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>433017-002.1</i>		CAUSE OF DEATH (A) <i>Cardiac Arrest.</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>1) Same cavitating TBC, active 10 yr 2) Seizure disorder - etiology unknown 12 yr</i>			
19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>9 Dec 1966</i> to <i>10 Dec 1966</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>10 Dec 1966</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.			
23A. SIGNATURE <i>Dudley A Raine Jr</i>		23B. DATE SIGNED <i>10 Dec 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Dudley A. Raine, Jr.</i>		23D. ADDRESS <i>#21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>12-14-66</i>	24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem. Pk.</i>	24D. LOCATION (City, town, or county) (State) <i>Arbutus Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1966</i>	25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>	25C. FUNERAL DIRECTOR ADDRESS <i>George G. Kelson 1348 N. Calhoun St.</i>	

Charles Amos

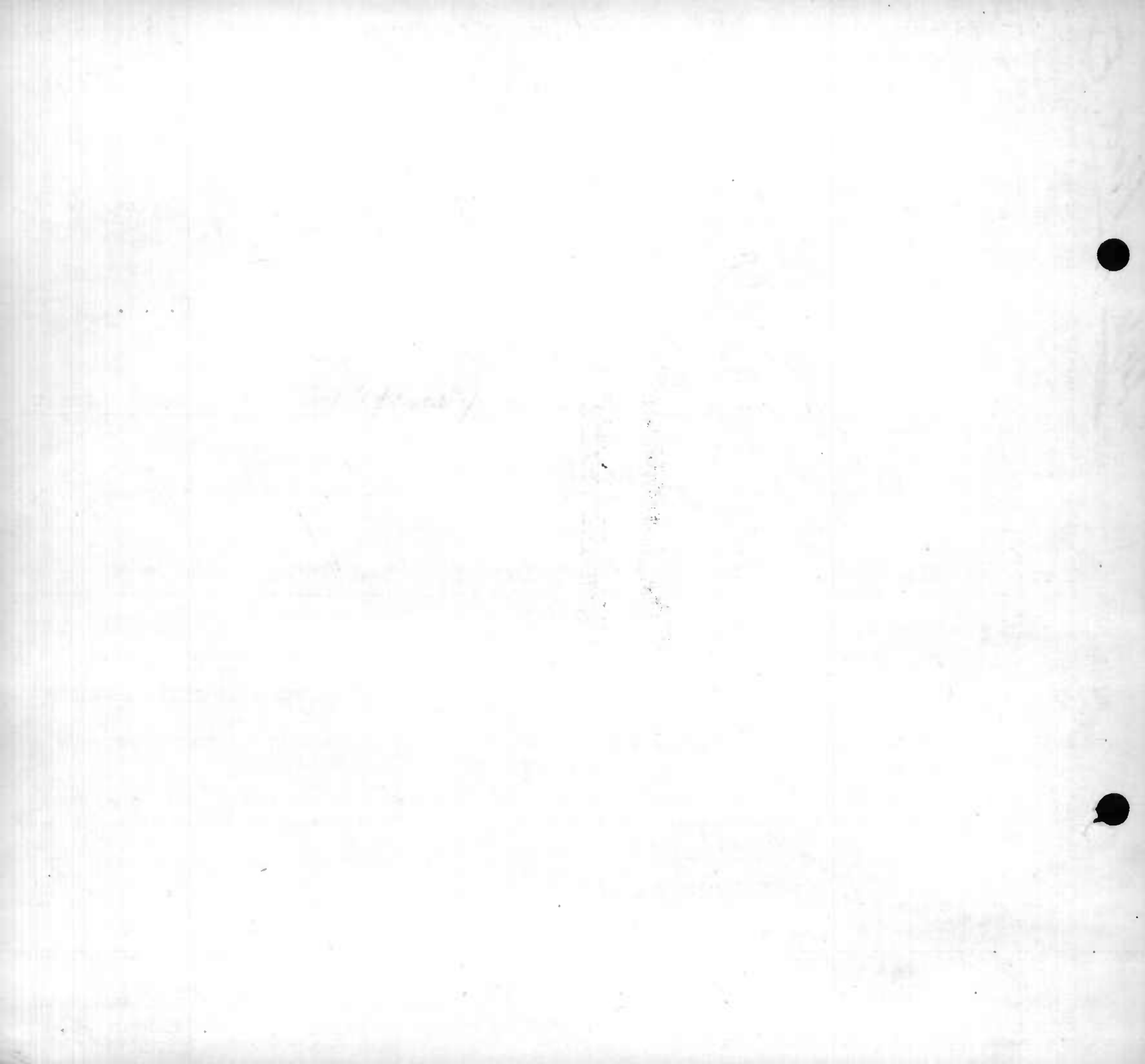
2) Subject of the study was  
somebody TBC, etc.

Philip H. H. H.

Funeral Director: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12330		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12350	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) William Ford MILBURN		2. DATE AND HOUR OF DEATH 12-10-66 3 41 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION: UNIVERSITY HOSPITAL 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY: Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 1312 EUTAW PL. Near Bldg 11-04					
5. SEX: M	6. RACE: Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Separated	8. DATE OF BIRTH: 1-27-93	9. AGE (In years lost birthday): 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): P
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): P		10B. KIND OF BUSINESS OR INDUSTRY: -	11. BIRTHPLACE (State or foreign country): Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: SAMUEL MILBURN		14. MOTHER'S MAIDEN NAME: unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): not known		16. SOCIAL SECURITY NO.: 717-07-6437		17. INFORMANT: Eunice Milburn 1312 Eutaw Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Ruptured thoracic aortic aneurysm - (B) DUE TO (C) Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH: probably 1 yr			
19A. DATE OF OPERATION: 12-10-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ruptured aortic aneurysm		20A. AUTOPSY? (Yes or No): -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): -	
21D. TIME OF INJURY (APPROX.): -		21E. INJURY OCCURRED: White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?: -	
22. I certify that (I) (this hospital) attended the deceased from 12-9-66 19 to 12-10-66 19, that (I) (we) lost saw the deceased alive on 12-10-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE: [Signature]		23B. DATE SIGNED: -			
23C. PHYSICIAN'S NAME (Type): FRANK A. ADLER		23D. ADDRESS: University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify): Burial		24B. DATE: 12-13-66		24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.	
24D. LOCATION (City, town, or county): Baltimore, Maryland		24E. STATE: -			
25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1966		25B. NAME OF REGISTRAR: [Signature]		25C. FUNERAL DIRECTOR: George Kelson 1348 N. Calhoun St.	



66 12351

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12351

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LINDEN

L.

SANDERS

2. DATE AND HOUR PRONOUNCED DEAD

December 7, 1966

9:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3312 St. Ambrose Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

Nov. 11, 1897

9. AGE (In years  
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Financier

10B. KIND OF BUSINESS OR INDUSTRY

Loan Business

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Albert Leigh Sanders

14. MOTHER'S MAIDEN NAME

Carrie Townsend

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W #1

16. SOCIAL  
SECURITY NO.

212-09-3262

17. INFORMANT

ADDRESS

Mr. Oakley L. Sanders, 3312 St. Ambrose Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Traumatic Injuries.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Reisterstown Rd., S. of Rockfield Rd.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
12 7 '66 P

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto. 27-18

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/8/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

23B. DATE

12/10/66

23C. NAME of CEMETERY or CREMATORY

Greenmount Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

4611 Park Heights Ave.

2-23-32

1. The first part of the document is a letter from the Secretary of the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Secretary of the Board of Directors.

2. The second part of the document is a letter from the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Board of Directors.

3. The third part of the document is a letter from the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Board of Directors.

4. The fourth part of the document is a letter from the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Board of Directors.

5. The fifth part of the document is a letter from the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Board of Directors.

6. The sixth part of the document is a letter from the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Board of Directors.

7. The seventh part of the document is a letter from the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Board of Directors.

8. The eighth part of the document is a letter from the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Board of Directors.

9. The ninth part of the document is a letter from the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Board of Directors.

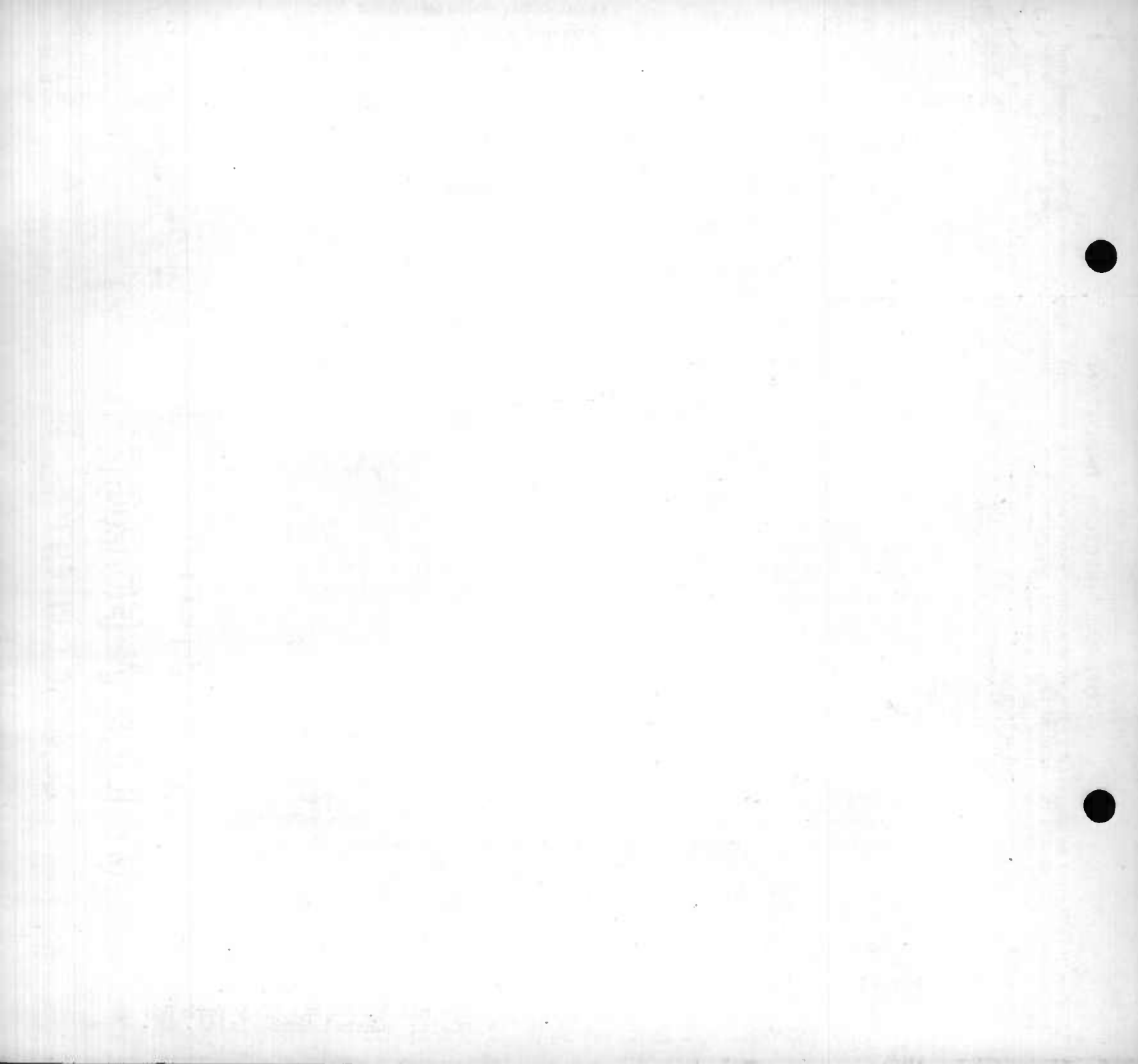
10. The tenth part of the document is a letter from the Board of Directors to the Board of Directors. The letter is dated 2-23-32 and is addressed to the Board of Directors. The letter is signed by the Board of Directors.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

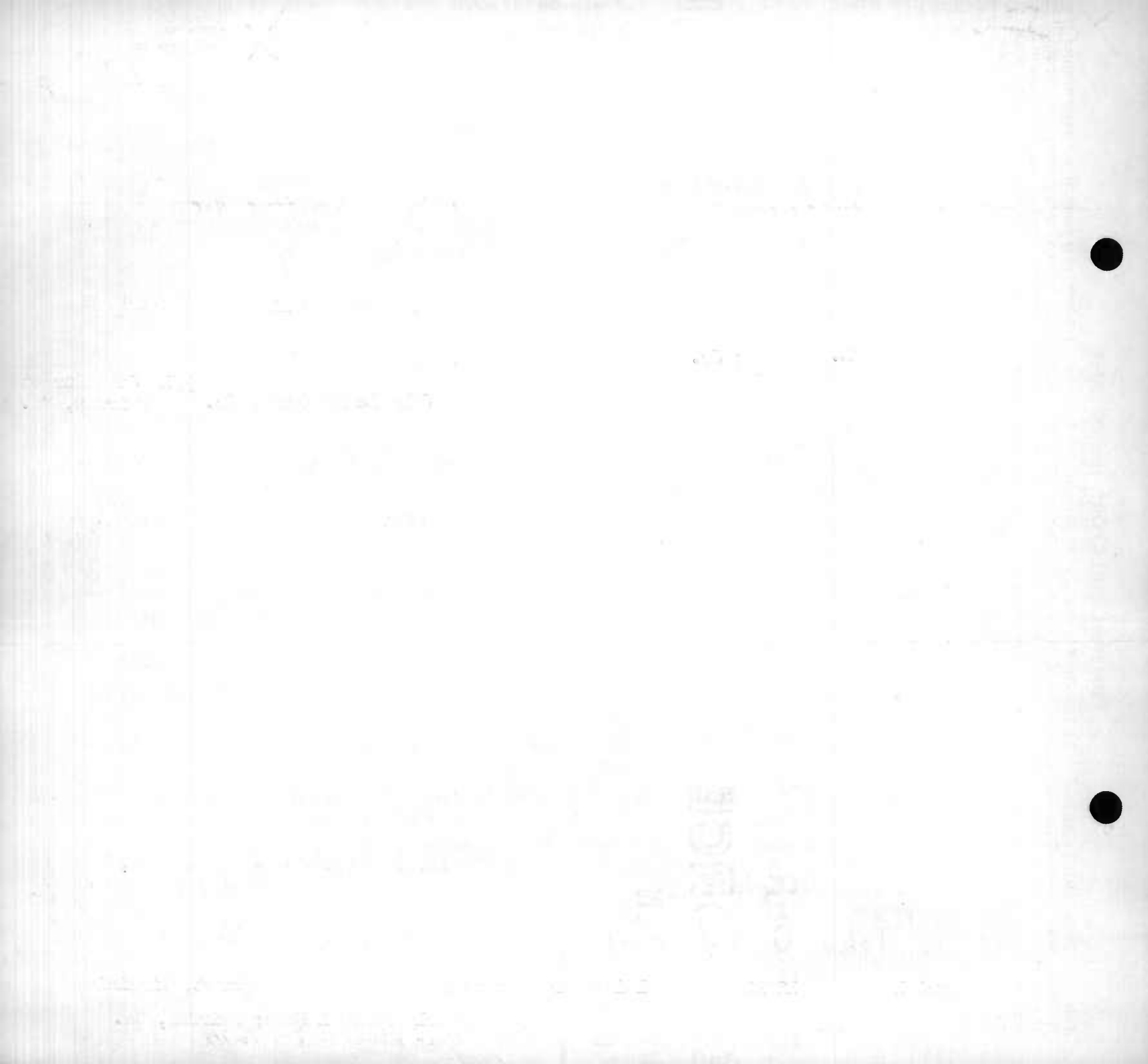
BIRTH NO. 66 12352		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12352	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>DORIS ANN LOETEL</b>		
2. DATE AND HOUR OF DEATH <b>12/8/66 6:00 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital 38</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>23-01</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>1432 S. Charles St.</b>		
			D. STREET ADDRESS (If rural, give location) <b>Baltimore, Md.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>3/6/18</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ROBERT C. LOETEL</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE TARTS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-6471</b>		17. INFORMANT <b>CHART</b> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>Broncho pneumonia</b> 4 days		
			(B) <b>Cerebral Decompression</b> 6 days		
			(C) <b>Cardiac Arrest</b> 6 days		
			(D) <b>? Post. Mediastinal Mass</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>POSTERIOR MEDIASTINAL MASS</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/2</b> 19 <b>66</b> to <b>12/8</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irvin M. Sopher M.D.</b>				23B. DATE SIGNED <b>12/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>IRVIN M. SOPHER M.D.</b>				23D. ADDRESS <b>University Hospital, Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>12/10/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Eugenia K. Seitz</b>	
25C. FUNERAL DIRECTOR <b>Seitz Funeral Home</b>		25D. ADDRESS <b>5209 York Rd. Balto. Md. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

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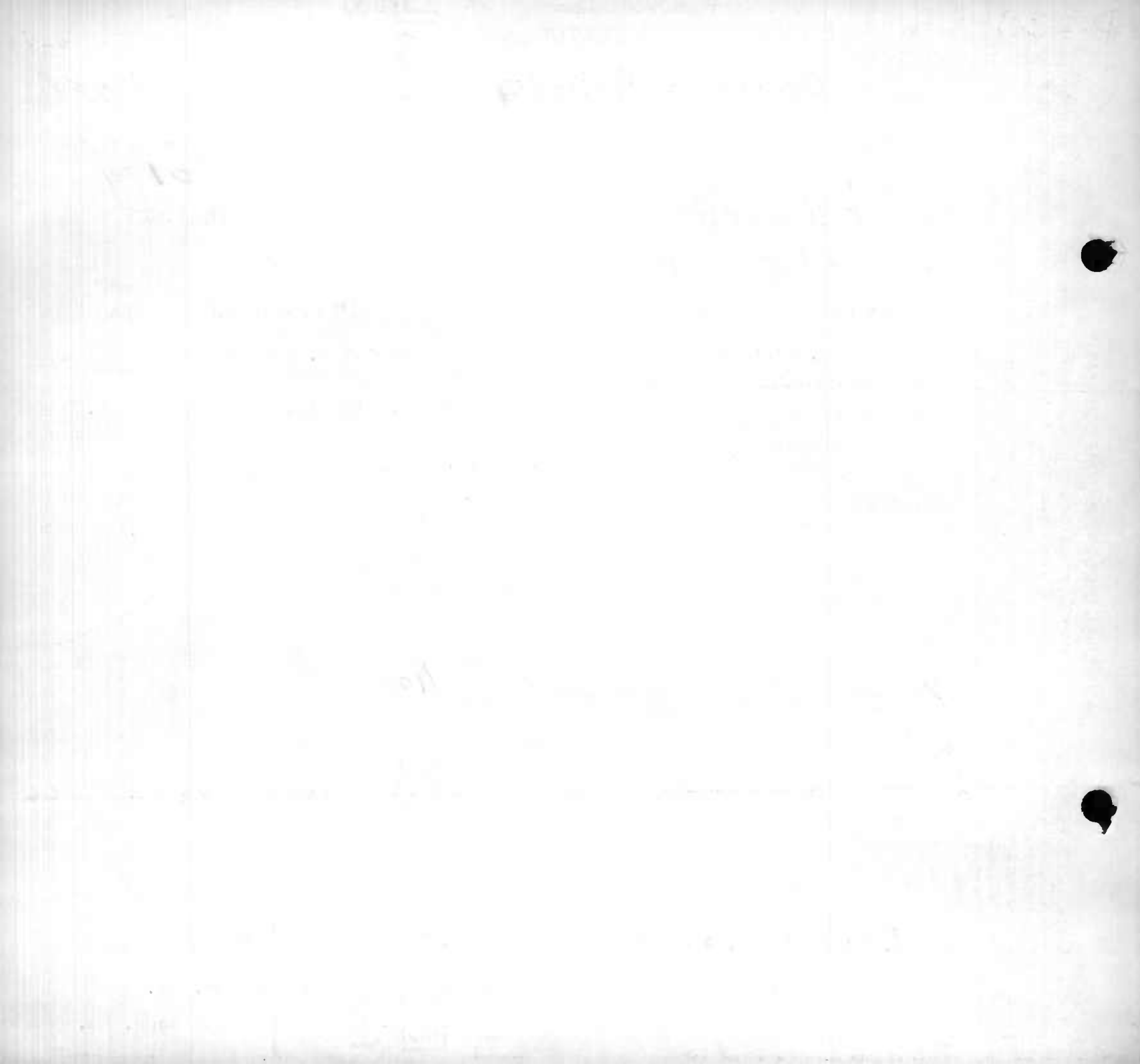
BIRTH NO. 66 12353		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12353	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <i>David Brent Young</i>			2. DATE AND HOUR OF DEATH <i>12/9/66</i> <i>531</i> p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 The Johns Hopkins Hospital</i> <i>401 N. Broadway</i> <i>Baltimore</i>			A. STATE <i>Virginia</i> B. COUNTY <i>Fairfax</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>V-43</i> D. STREET ADDRESS (If rural, give location) <i>10300 Stratford Ave.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>child</i>	8. DATE OF BIRTH <i>3/22/59</i>	9. AGE (In years last birthday) <i>7</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i>		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <i>Durham, North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John L. Young, Jr.</i>			14. MOTHER'S MAIDEN NAME <i>Annette Ajee</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. —	17. INFORMANT <i>John LeRoy Young, Jr.</i>		
18. <i>289.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Renal Failure</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cystinosis</i>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>7-8 mos.</i> <i>probably congenital (7 yrs)</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2 none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from <i>11/21/66</i> to <i>12/9/66</i> and that (I) (we) last saw the deceased alive on <i>12/9/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John D. Johnson</i>			23B. DATE SIGNED <i>12/9/66</i>		
23C. PHYSICIAN'S NAME (Type) <i>John D. Johnson</i>			23D. ADDRESS <i>The Johns Hopkins Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/12/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bouldin Church Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Stuart, Virginia</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Everly Funeral Home; Fairfax, Va.</i>	
				By <i>amulst, nys</i>	



# FUNERAL DIRECTOR: IMPORTANT

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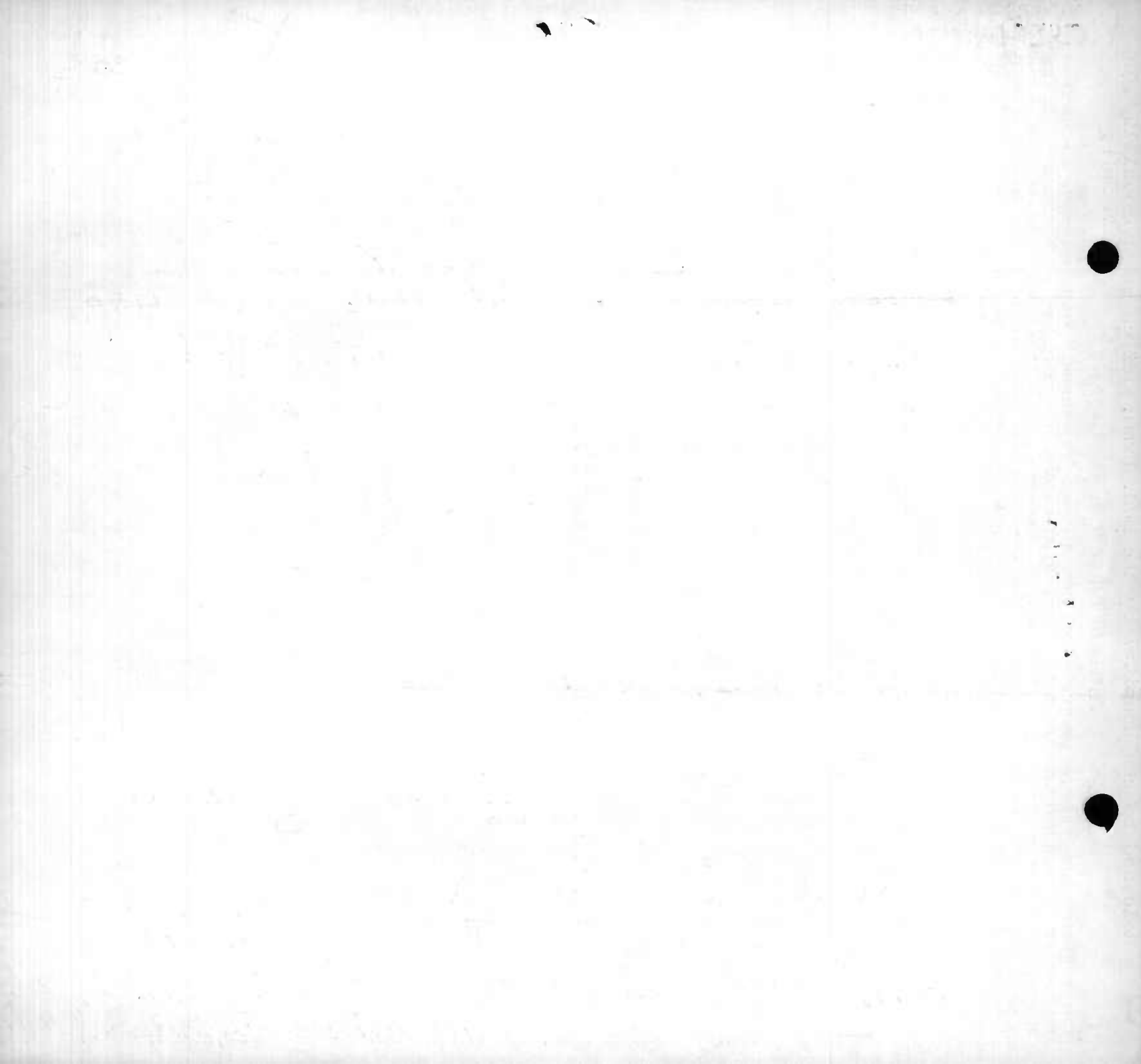
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12354</u>	
BIRTH NO. <u>66 12354</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>George A. Pickett</u>		2. DATE AND HOUR OF DEATH <u>12-8-66</u> <u>1:45 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>26-07</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>21224</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hosp.</u>		D. STREET ADDRESS (If rural, give location) <u>708 S. Oldham St.</u>			
5. SEX <u>M</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>3-22-1887</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>David M. Pickett</u>		14. MOTHER'S MAIDEN NAME <u>Mariah L. Snyder</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>George W. Pickett, 708 S Oldham St.</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>? MI</u>		CAUSE OF DEATH (A) DUE TO <u>ASCVDs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>year</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>at</del> (this hospital) attended the deceased from <u>11-29</u> 19 <u>66</u> to <u>12-8</u> 19 <u>66</u> , that <del>on</del> (we) last saw the deceased alive on <u>12-8</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rifat A. Abouss</u> M.D.				23B. DATE SIGNED <u>12-8-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Rifat A. Abouss</u>		23D. ADDRESS M.D. <u>1213 Light St.</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/11/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Howard Chapel</u>	
24D. LOCATION <u>Long Corner, Md.</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>		25C. FUNERAL DIRECTOR <u>Olin L. Moleworth, Damascus, Md.</u>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12355		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED No. 66 12355	
M.E. CASE NO.		CÉRTIFICATE OF DEATH		Registered No. 66 12355	
1. NAME OF DECEASED (Type or Print) Clara Robinson		2. DATE AND HOUR OF DEATH 12-6-66 19 <sup>30</sup> A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Calvert Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Prince Frederick 54-00 D. STREET ADDRESS (If rural, give location) Rt #1 Box 175			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6-27-98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Rufus Bowen		14. MOTHER'S MAIDEN NAME Edith Stafford	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -		17. INFORMANT sister in law by phone	
18. 9/6/01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH A) Respiratory failure B) 70% burn C) Due to		INTERVAL BETWEEN ONSET AND DEATH immediate	
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Prince Frederick Md. 54-00	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 7 AM 12-3-66		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Reached across stove, sweated caught on fire	
22. I certify that (I) (this hospital) attended the deceased from 12-3-66 19 to 12-6-66 19, that (I) (we) last saw the deceased alive on 12-6-66 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philander B. Briscoe Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-6-66	
23C. PHYSICIAN'S NAME (Type) Philander B. Briscoe Jr.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/66		24C. NAME of CEMETERY or CREMATORY Asbury Cemetery	
24D. LOCATION Barstow Calvert Co. Md.		24E. LOCATION (City, town, or county) (State) Barstow Calvert Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR A.A. Harkness		25C. FUNERAL DIRECTOR A.A. Harkness & Son, Port Republic, Md.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 12356	
BIRTH NO. <u>JANE 42356</u>		M.E. CASE NO.		1. NAME OF DECEASED <u>JANE L. Hawley</u>	
(Type or Print)		2. DATE AND HOUR OF DEATH <u>12-7-66</u> <u>4:07</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mary Hospital</u>		A. STATE <u>PA</u> B. COUNTY <u>Brodbecks</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>R.D. #1</u>			
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u>	
8. DATE OF BIRTH <u>Nov 15 1966</u>		9. AGE (In years last birthday) <u>22</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Employed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hanover, PA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Thomas Hawley</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Delores Stable</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>William T Hawley, Brodbeck, PA</u>	
18. <u>751.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		<u>Respiratory arrest</u>			
ANTECEDENT CAUSES		<u>Encephalitis</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>11-23-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Encephalitis</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-18</u> 19 <u>66</u> to <u>12-7-66</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12-7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-7-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Law Gulbransen</u>		M.D. <u>Mary Hospital</u>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-10-66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem</u>	
24D. LOCATION (City, town, or county) <u>Pikesville Md</u>		(State) <u>Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>	
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Bridget Fungel Home</u>		ADDRESS <u>[Address]</u>	

Brook 1000  
R. D. #1

Female White West Indian House Wren

House Finch —

William Thomas Hawley

William Thomas Hawley —

Female House Finch  
R. D. #1  
Brook 1000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 12357					CERTIFICATE OF DEATH		Registered No. 66 12357			
1. NAME OF DECEASED (Type or Print) <b>CARL A. Brittingham</b>					2. DATE AND HOUR OF DEATH <b>12-8-66 12:20 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3737 Roland Ave</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>1307</b> D. STREET ADDRESS (If rural, give location) <b>3737 Roland Avenue</b>					
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>Apr. 28, 1904</b>		9. AGE (In years last birthday) <b>62</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wireman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Electrical Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George R. Brittingham</b>					14. MOTHER'S MAIDEN NAME <b>Laura V. Melvin</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>21703 6364</b>		17. INFORMANT <b>Mary E. Brittingham</b>			
18. <b>1966</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Rumerus</b>					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>Sept. 1966</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(A) DUE TO		(B) DUE TO			
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 20, 1966</b> to <b>Dec. 8, 1966</b> , that (I) <del>was</del> last saw the deceased alive on <b>Dec. 7, 1966</b> and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.										
23A. SIGNATURE <b>Reuben Hoffman</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>12-9-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>REUBEN HOFFMAN</b>					23D. ADDRESS <b>546 W. 36th St., Baltimore, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-12-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cem.</b>			24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>			25C. FUNERAL DIRECTOR <b>Burgee Funeral Home</b>			ADDRESS <b>3631 Falk Rd</b>		

3737 Holand Ave

Mal White, Manager

Williamson Electric Works Maryland

George R. Birmingham

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Louis V. Melton

George E. Birmingham

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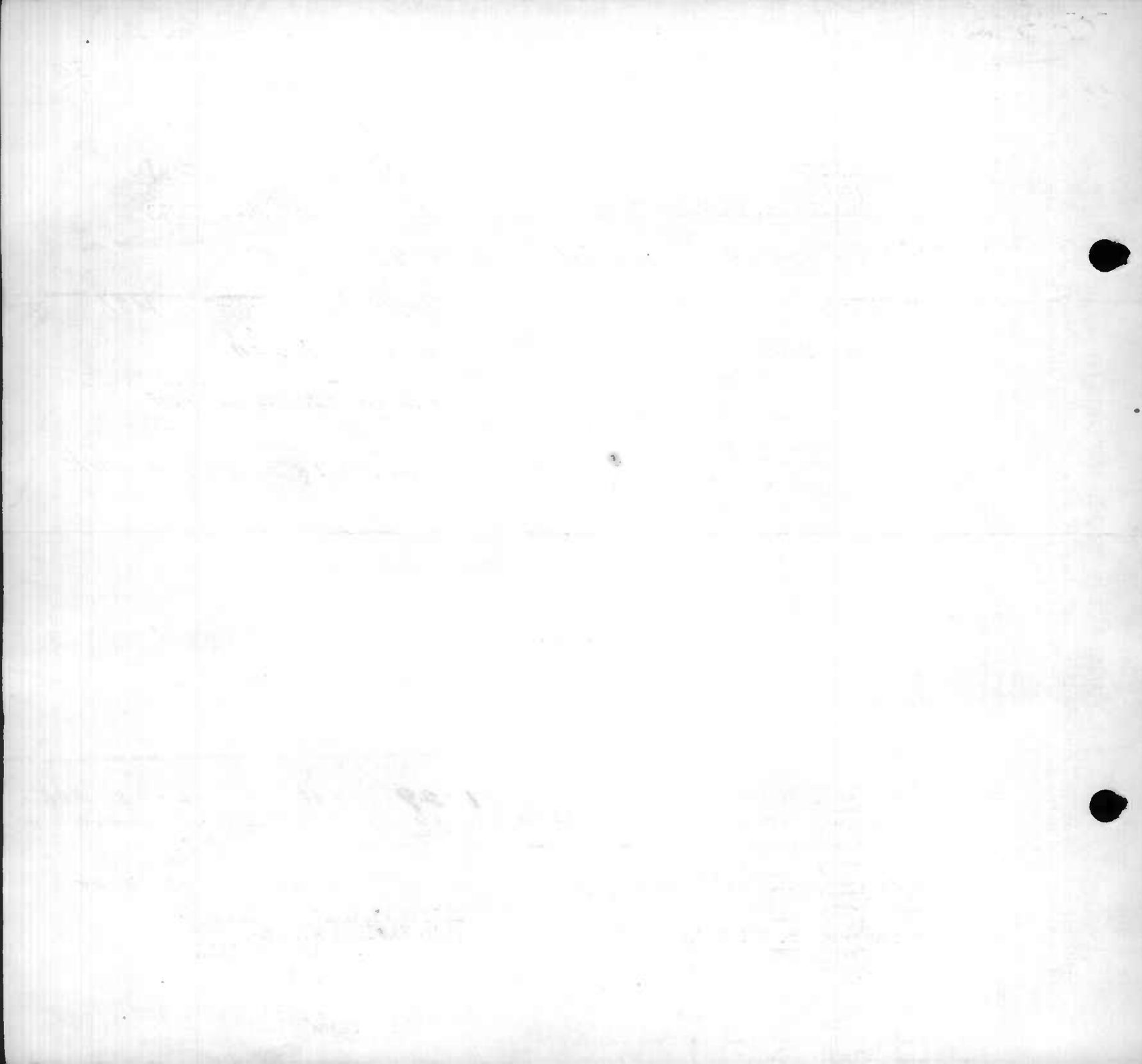
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12358		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12358	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED Elizabeth Joan CUDNIK		2. DATE AND HOUR OF DEATH Dec. 8, 1966 12 30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
31		D. STREET ADDRESS (If rural, give location)			
		3155 Lyndale Ave 21213			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-18-47	9. AGE (In years last birthday) 19	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Bean		14. MOTHER'S MAIDEN NAME Mary Trojan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS-BCH 4940 EASTERN AVENUE Baltimore City Hospital Chpt	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Malignant Melanoma DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) solong the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-29-66 to 12-8-66, that (I) (we) lost saw the deceased alive on 12-8-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick S. Mishkin		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-8-66	
23C. PHYSICIAN'S NAME (Type) Frederick S. Mishkin		M.D. 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/66		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	
				24D. LOCATION Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1966		25B. NAME OF REGISTRAR Robert E. Fajana		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12359				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12359	
M.F. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MISS HELEN M. NICOL				DEC. 7, 1966		7 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE HOPKINS APTS 3100 ST. PAUL STREET				MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-02 D. STREET ADDRESS (If rural, give location) 3100 ST. PAUL STREET THE HOPKINS			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
FEMALE	WHITE	SINGLE	MAR. 7, 1902	64			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
AT HOME				PETROLIA, ONTARIO		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM R. NICOL				MARGARET E. KAVANAGH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						ROBERT M. NICOL 3100 ST. PAUL ST.	
18. 72201 CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) RHEUMATOID ARTHRITIS DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) HISTORIC HERNIA 4 months prior.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from September 26 1962 to December 7 1966, that (I) (we) last saw the deceased alive on December 6 1966 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. Grafton Hersperger				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED December 7, 1966	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger, M. D.				23D. ADDRESS 214 Medical Arts Building			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL 12/9/66		12/9/66		MORELAND MEMORIAL PARK		BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
DEC 12 1966		R. E. Taylor		H. W. MEARS & SON 805 N. CALVERT ST.			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12360</u>	
BIRTH NO. <u>66 12360</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>66 12360</u>					
1. NAME OF DECEASED (Type or Print) <u>EVERETT, Wilbur Benjamin</u>		2. DATE AND HOUR OF DEATH <u>December 8, 1966</u>   <u>3:30 A. M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>27 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Washington</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Hancock</u> D. STREET ADDRESS (If rural, give location) <u>71-00</u> <u>107 E. Main St.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10-1-15</u>	9. AGE (In years lost birthday) <u>51</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sand Miner</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Earl T. Everett</u>		14. MOTHER'S MAIDEN NAME <u>Annie Prevost</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>220-10-3310</u>		17. INFORMANT <u>Records</u> <u>V. A. Hospital, Baltimore, Md. 21218</u>	
18. <u>002.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>ACTIVE Tuberculosis, pulmonary, far-</u> <u>advanced with broncho pleural</u> <u>fistula, right</u>		CAUSE OF DEATH (A) <u>Tuberculosis, pulmonary, far-</u> TO <u>advanced with broncho pleural</u> fistula, right (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>Since 1943</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>December 5,</u> 19 <u>66</u> to <u>December 8,</u> 19 <u>66</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>December 8,</u> 19 <u>66</u> and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE  <u>Donald H. Hooker</u> DONALD H. HOOKER				23B. DATE SIGNED <u>12/8/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Donald H. Hooker</u>		23D. ADDRESS M.D. <u>V. A. Hospital, Baltimore, Md. 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12.11.66</u>		24C. NAME of CEMETERY or CREMATORY <u>WHIPS COVE</u>	
24D. LOCATION (City, town, or county) (State) <u>FULTON COUNTY PENNA.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Talburt</u>		25C. FUNERAL DIRECTOR <u>Howard J. Stone</u>	
				ADDRESS <u>md</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12361</span>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <span style="font-size: 1.5em;">66 12361</span></p> <p>M.E. CASE NO. <span style="font-size: 1.5em;">IRENE</span></p> <p>1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">Alice La Voie</span></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">Dec. 9, 1966 3:00 A.M.</span></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 1.5em;">Maryland General Hospital</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <span style="font-size: 1.5em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">Baltimore Co.</span></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</p> <p style="font-size: 1.5em;">Brodshaw 53-00</p> <p>D. STREET ADDRESS (If rural, give location)</p> <p style="font-size: 1.5em;">Old Philadelphia Road</p>		
5. SEX <span style="font-size: 1.5em;">F</span>	6. RACE <span style="font-size: 1.5em;">W</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
		<span style="font-size: 1.5em;">widowed</span>	<span style="font-size: 1.5em;">1/6/00</span>	<span style="font-size: 1.5em;">66</span>	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<span style="font-size: 1.5em;">Gas Mask Assembler</span>		<span style="font-size: 1.5em;">U.S. Govt.</span>	<span style="font-size: 1.5em;">Maryland</span>		<span style="font-size: 1.5em;">U.S.A.</span>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<span style="font-size: 1.5em;">Samuel Jones</span>			<span style="font-size: 1.5em;">Edith Smith</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
<span style="font-size: 1.5em;">no</span>		<span style="font-size: 1.5em;">220-22-0882</span>	<span style="font-size: 1.5em;">Charles Jones 4214 E. Joppa Rd, Balto. Md</span>		
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
<p><span style="font-size: 1.5em;">410X I</span></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					
<p>(A) <span style="font-size: 1.5em;">Pulmonary edema</span></p> <p>DUE TO <span style="font-size: 1.5em;">rheumatic heart disease</span></p> <p><span style="font-size: 1.5em;">3 mitral stenosis</span></p> <p>(B) DUE TO</p> <p>(C)</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p><span style="font-size: 1.5em;">house shock kidney</span></p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<span style="font-size: 1.5em;">2</span>				<span style="font-size: 1.5em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">Nov. 25</span> 1966 to <span style="font-size: 1.5em;">Dec. 9</span> 1966, that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">Dec. 9</span> 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<span style="font-size: 1.5em;">W. Michael Gould</span>				<span style="font-size: 1.5em;">12/9/66</span>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<span style="font-size: 1.5em;">W. Michael Gould</span>				<span style="font-size: 1.5em;">Maryland General Hospital, Balto., Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<span style="font-size: 1.5em;">Burial</span>	<span style="font-size: 1.5em;">Dec. 12, 1966</span>	<span style="font-size: 1.5em;">Salem Cemetery</span>		<span style="font-size: 1.5em;">Upper Falls Balto. Co., Md.</span>	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
		<span style="font-size: 1.5em;">Howard K. McComas &amp; Son, Abingdon, Md. 21009</span>			

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Marshall  
Baltimore

Marshall General Hosp. Tel

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Marshall

Marshall

Edith Smith

Samuel Jones

350-35-0845 (Continued)  
Charles Jones  
Marshall E. Jones, Jr.

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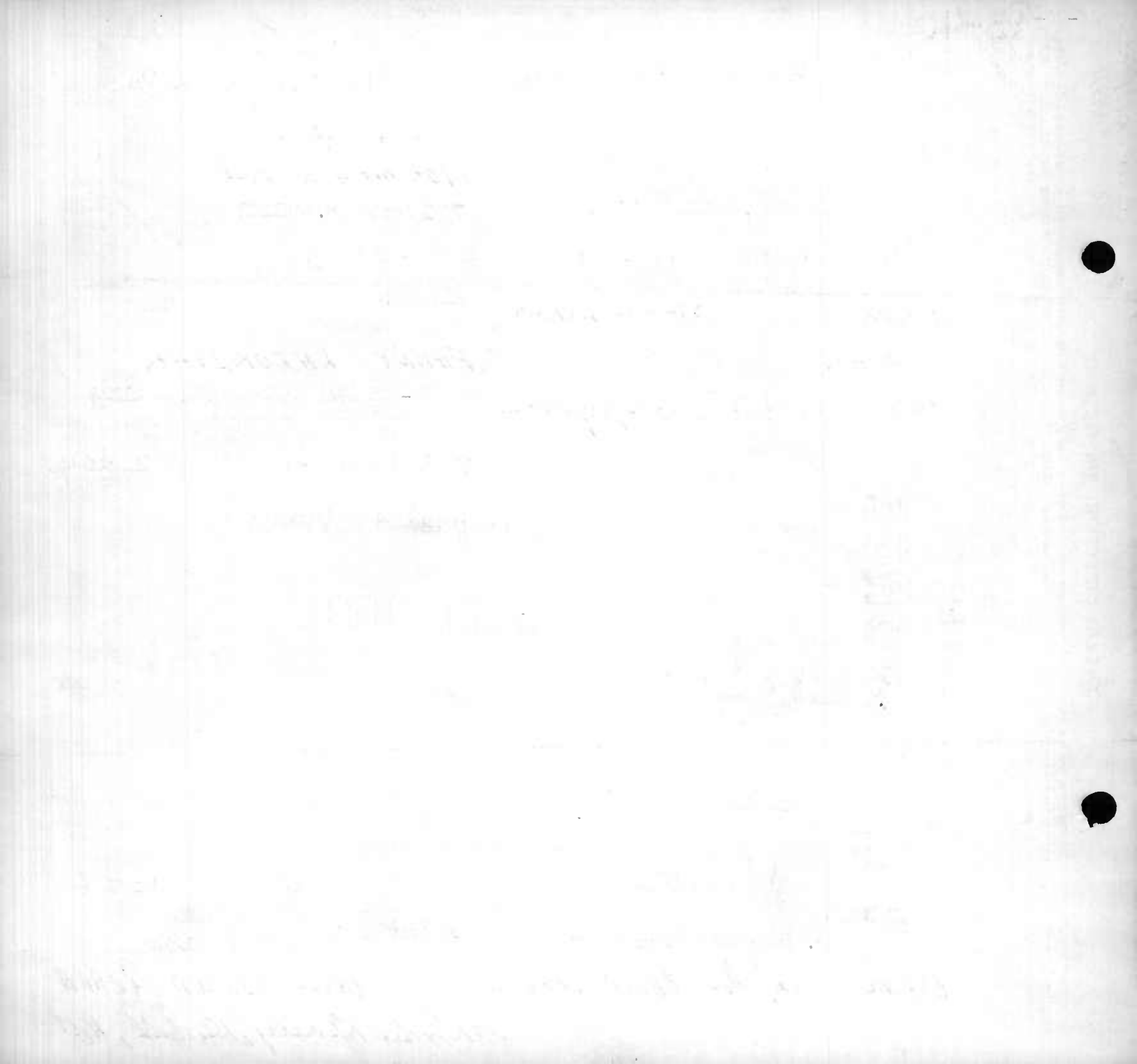
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*Marshall Jones*

48-24-6000  
12/4/66  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

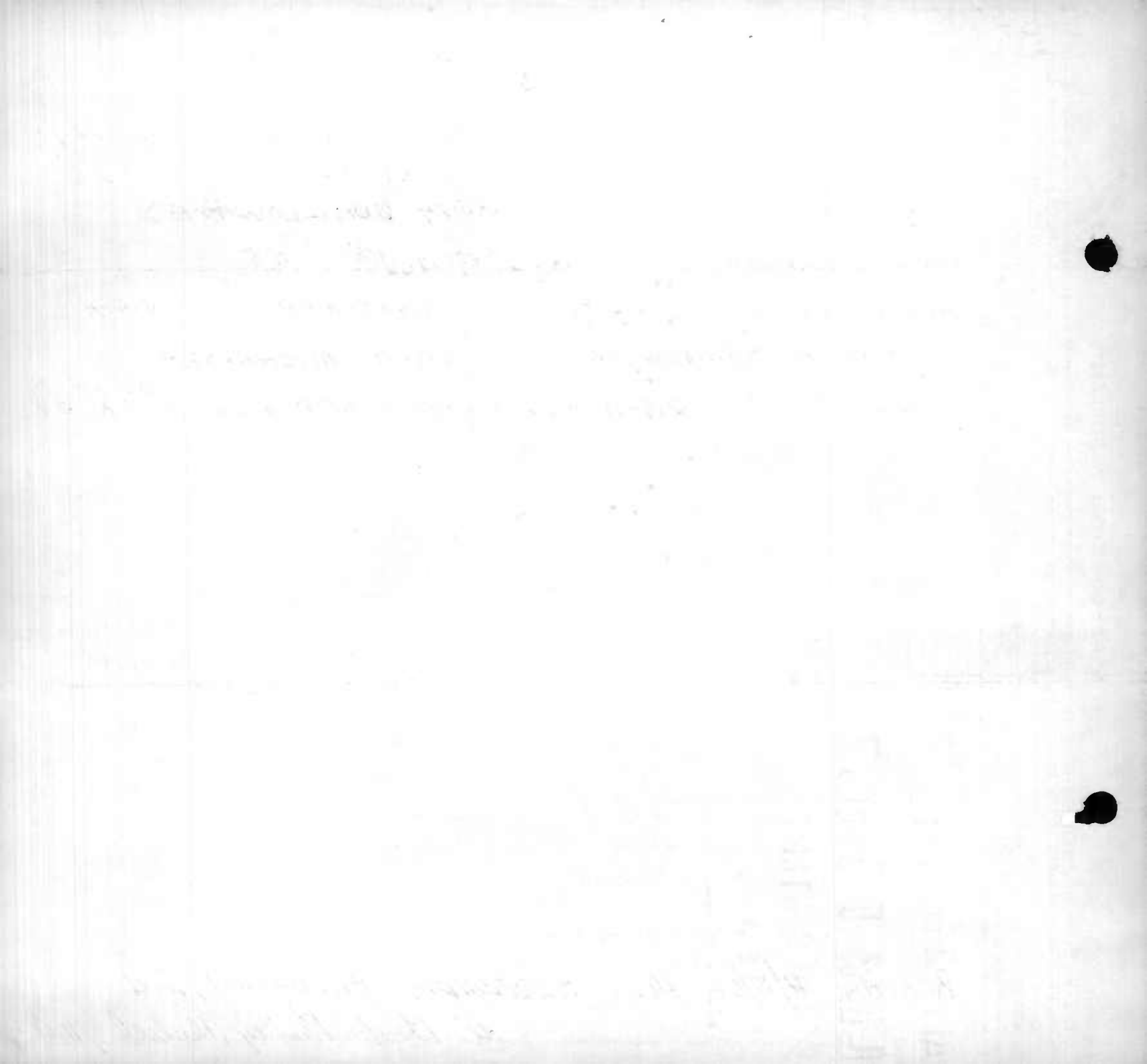
48-24-6000 66 12362		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12362	
CERTIFICATE OF DEATH					
BIRTH NO. 12362		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BALIG ROSKY Myron</b>	
2. DATE AND HOUR OF DEATH <b>12.7.66. 12.30 PM.</b>		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>		A. STATE <b>MARYLAND, BALTIMORE Co.</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>7703 MEATH Rd 53-00</b> D. STREET ADDRESS (If rural, give location) <b>7703 Meath Rd. 21222</b>			
5. SEX <b>Me</b>	6. RACE <b>WHITE</b>	7. MARRIED; NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3-10-07</b>	9. AGE (In years lost birthday) <b>59</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PICKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL MILLER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JOHN</b>		14. MOTHER'S MAIDEN NAME <b>FANNY LAZORZIAK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII 376/10/7582</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RECORDS BCH 4940 EASTERN AVENUE 21224</b>	
18. <b>6-76 X 12-260 X</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Acute Peritonitis</b> DUE TO		<b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Perforated Viscus.</b> DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Diabetes Mellitus</b>			
19A. DATE OF OPERATION <b>12-6-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute abdomen</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>12.6.1966</b> to <b>12.7.1966</b> , that (I) (we) last saw the deceased alive on <b>12.7.1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Mathur</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12.7.66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Amburish Mathur</b>		23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/19/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>BELLE VERNON</b>	
24D. LOCATION (City, town, or county) (State) <b>BELLE VERNON, PENNA.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Reuben E. Farkas</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mr. Joseph Bradley, R. 2nd St., Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department										
66 12363					CERTIFICATE OF DEATH		Registered No. 66 12363			
BIRTH NO. 66 12363					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Mr John A. Seamon, JR.					2. DATE AND HOUR OF DEATH 12.7.66 5.45 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital					A. STATE md. BALTIMORE (21222)					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) DUNDALK 53-00					
					D. STREET ADDRESS (If rural, give location) 3014 DUNGLON ROAD					
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH SEPT 14, 1908		9. AGE (In years last birthday) 58		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADMINISTRATOR		10B. KIND OF BUSINESS OR INDUSTRY EDUCATION		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME JOHN A. SEAMON-SR					14. MOTHER'S MAIDEN NAME VIOLET MICHALSKA					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 219-18-8162		17. INFORMANT ELIZABETH MCD. SEAMON (AS IN ADDRESS ABOVE)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Cerebro/Vascular Accident DUE TO (B) Anteroseptal myocardial infarction DUE TO color disease. (C)					
INTERVAL BETWEEN ONSET AND DEATH 2 days										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0 none			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -			21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location) -				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? -				
22. I certify that (I) (this hospital) attended the deceased from 12/5/66 19 66 to 12/7/66 19 66 that (I) (we) last saw the deceased alive on 12.7. 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Narong Ruangruachira M.D.					23B. DATE SIGNED 12.7.66					
23C. PHYSICIAN'S NAME (Type) NARONG RUANGRUACHIRA M.D.					23D. ADDRESS Mercy Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 12/10/66		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD			
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1966			25B. NAME OF REGISTRAR Robert E. Saylor, M.D.			25C. FUNERAL DIRECTOR W. Joseph Bailey, Bethesda, Md.			ADDRESS	





5-630

66 12364

BALTIMORE CITY HEALTH DEPARTMENT

66 12364

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LOUIS SHERROD

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1966

9:50 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1330 W. Mosher Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1/29/31

9. AGE (In years  
last birthday)

35

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Self

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Willie Sherrod

14. MOTHER'S MAIDEN NAME

Hella Roberson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

212-28-6772

17. INFORMANT

ADDRESS

Ethel Keel-106 N. Mt. Olivet St.

18. E916.01

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A).....  
DUE TO

Extensive burns

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B).....  
DUE TO

Conflagration

(C).....

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

(Living room)

1330 W. Mosher Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

12-2-66 2:10 P. m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell asleep while smoking

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURECharles S. Springate, M.D.  
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/14/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 12 1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Wm. L. Chetman

ADDRESS

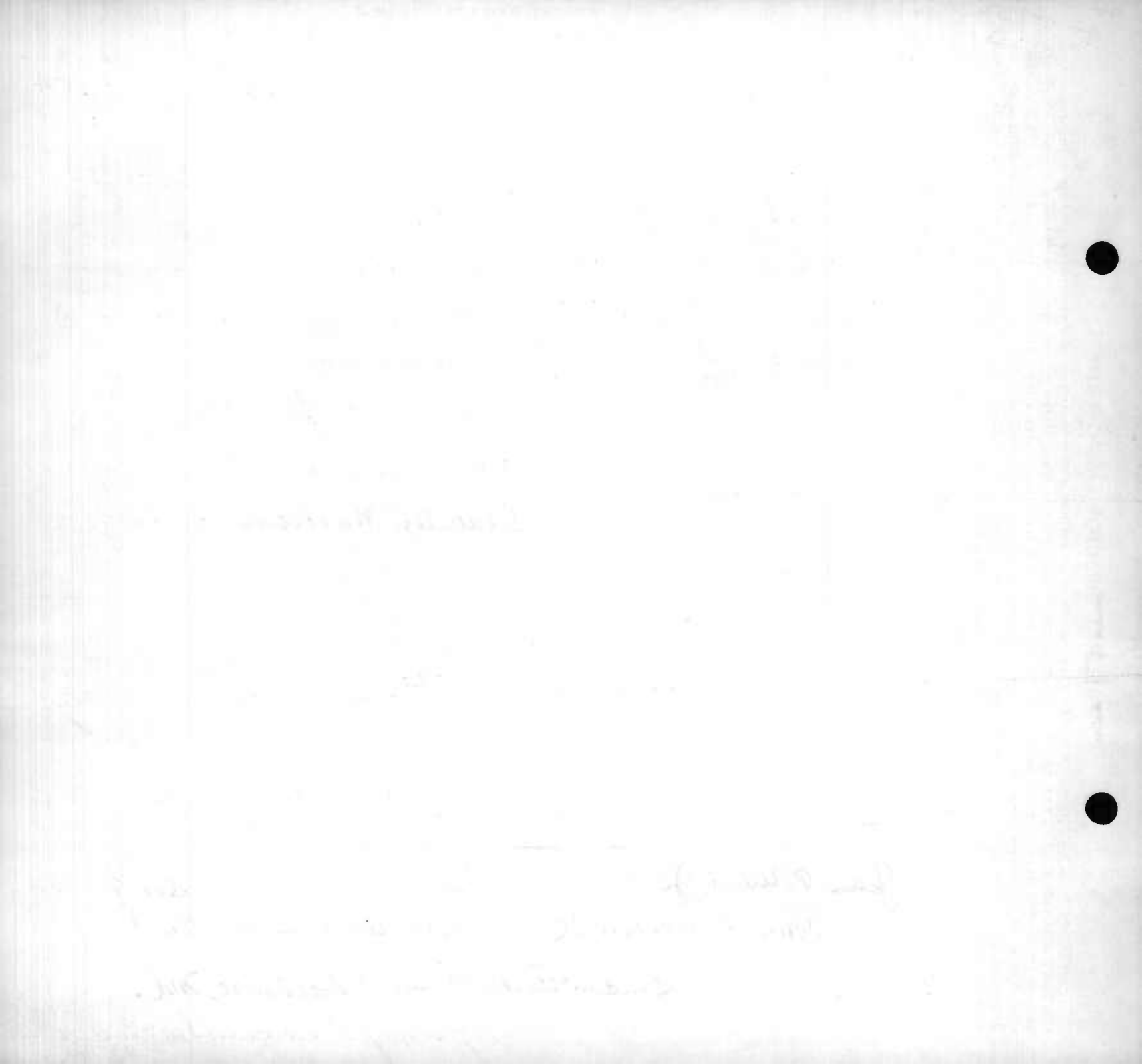
1701 Mt. Culler St



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12365</u>	
BIRTH NO. <u>66 12365</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Helen A. Blunt</u>		2. DATE AND HOUR OF DEATH <u>12/19/66</u> <u>5:15 A.M.</u>	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21-02</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>00914 Ryan St.</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>914 Ryan St.</u>	
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>3/25/1909</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Southern Packing Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Thomas Woods</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Dolores Young</u>	
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Arteriosclerotic Heart Disease</u> DUE TO (B) <u>Diabetes Mellitus</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> <u>1958</u> to <u>12/19</u> <u>1966</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>12/13</u> <u>1966</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>John P. Urlock Jr.</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>Dec 9, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCK JR.</u>		23D. ADDRESS <u>1227 Washington Blvd</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/12/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Landon Park Comm.</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>		24F. NAME OF REGISTRAR <u>Robert E. Farley</u>	
24G. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>		24H. NAME OF REGISTRAR <u>Robert E. Farley</u>		24I. FUNERAL DIRECTOR <u>John J. Cowan &amp; Son Inc.</u>	
24J. ADDRESS <u>901 St. 23rd Md.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No.			
66 12366										66 12366			
BIRTH NO.													
M.E. CASE NO.													
1. NAME OF DECEASED (Type or Print)										2. DATE AND HOUR OF DEATH			
Stonesifer, Lydia, Arlean										12/9 1966 7:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY			
University Hospital										Md. Carroll Co.			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)										56-27			
D. STREET ADDRESS (If rural, give location)										Rd #1			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
F	W	Divorced		5/7 1920	46	Factory Worker		Md.		U.S.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
Shoe Factory				Shoe Factory		William Erb			Margaret Reaver				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
No				212-24-6127		Mrs. Arthur Yingling, Westminster, Md R-1							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										(A) Brain stem Sarcoma		8 hr.	
ANTECEDENT CAUSES										(B) Brain Stem Infarction		10 hr.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C) Post Op Removal Acoustic Nerve		24 hr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
Dec 8th 66				Acoustic Tumor									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?					
				While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from Dec 1st 1966 to Dec 9th 1966, that (I) (we) last saw the deceased alive on Dec 9th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE										23B. DATE SIGNED			
Vigil Thor Thorsteinsson										Dec 9th 1966			
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS			
Vigil Thor Thorsteinsson M.D.										903 Nottingham Rd. Balto 29 Md			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
Burial				12/12/66		Pleasant Valley Cemetery				Pleasant Valley, Carroll Co., Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR					
DEC 12 1966				G. E. Farley				Richard A. Little Newell Funeral Home, Baltimore Linthicum, Md					

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**FUNERAL DIRECTOR: IMPORTANT**

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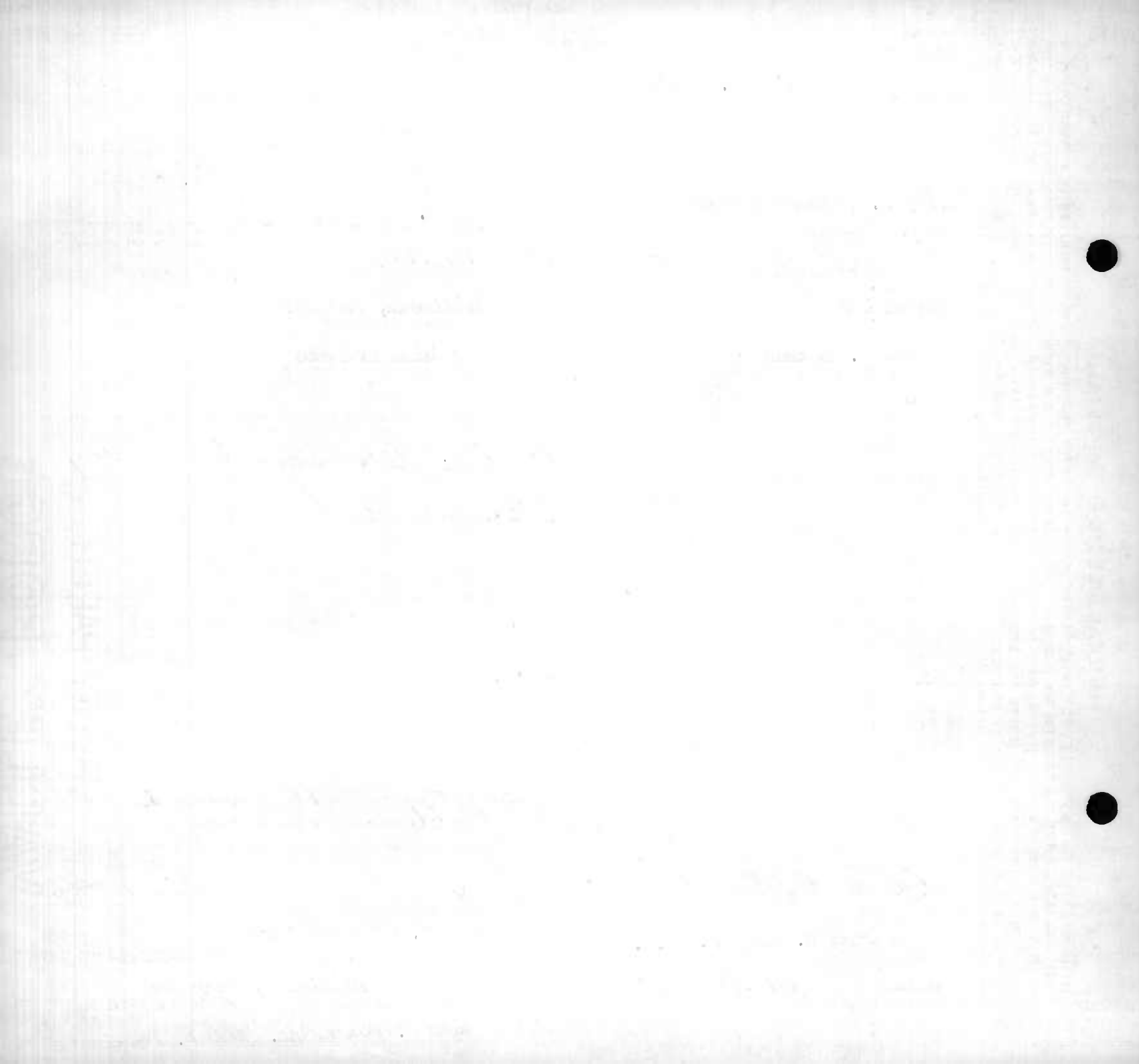
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12367	
BIRTH NO. 66 12367		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>Hans A. Carlsen</b>		
2. DATE AND HOUR OF DEATH			Dec 8th. 1966 7:20 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Saint Agnes Hospital Caton &amp; Wilkens Aves. 21229</b>			A. STATE <b>Maryland</b> B. COUNTY <b>a.a.c.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3710 W. Bay Ave #25</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7/30/14</b>	9. AGE (In years lost birthday) <b>52</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Co. Printer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>National Stationary</b>		11. BIRTHPLACE (State or foreign country) <b>Mass</b>	
13. FATHER'S NAME <b>Hans.</b>			14. MOTHER'S MAIDEN NAME <b>HUGUSTA NELSEN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Family - Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>175X I</b>		CAUSE OF DEATH (A) DUE TO <b>Metastatic lymphoma, hydrothorax</b> (B) DUE TO <b>Embryonal cell carcinoma, metastatic</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1-3 days</b> <b>14 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (I APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 7 1966</b> to <b>Dec 8 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 8 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Philip Whelan</b>				23B. DATE SIGNED <b>12/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Philip Whelan</b>				23D. ADDRESS <b>ST Agnes Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/12/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Edgemoor</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. STATE <b>Md</b>		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>McCiney - 737</b>	
25D. ADDRESS		25E. ADDRESS			

TYPE 110001



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12368				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12368	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Florentina E. Hunter</i>				2. DATE AND HOUR OF DEATH <i>December 8, 1966</i> <i>3:30P</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>125 N. Potomac Street</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>125 N. Potomac Street</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12/5/1885</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John H. Burman</i>				14. MOTHER'S MAIDEN NAME <i>Louisa Letmate</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <i>420.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Cardiac decompensation</i> DUE TO (B) <i>Arteriosclerotic heart disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> 19 <i>66</i> to <i>Dec 2</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec 2</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Charles C. MacMinn M.D.</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Dec 9, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Charles C. MacMinn, M.D.</i>				23D. ADDRESS <i>2900 E. Baltimore Street</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/10/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St</i>			



FUNERAL DIRECTOR: IMPORTANT

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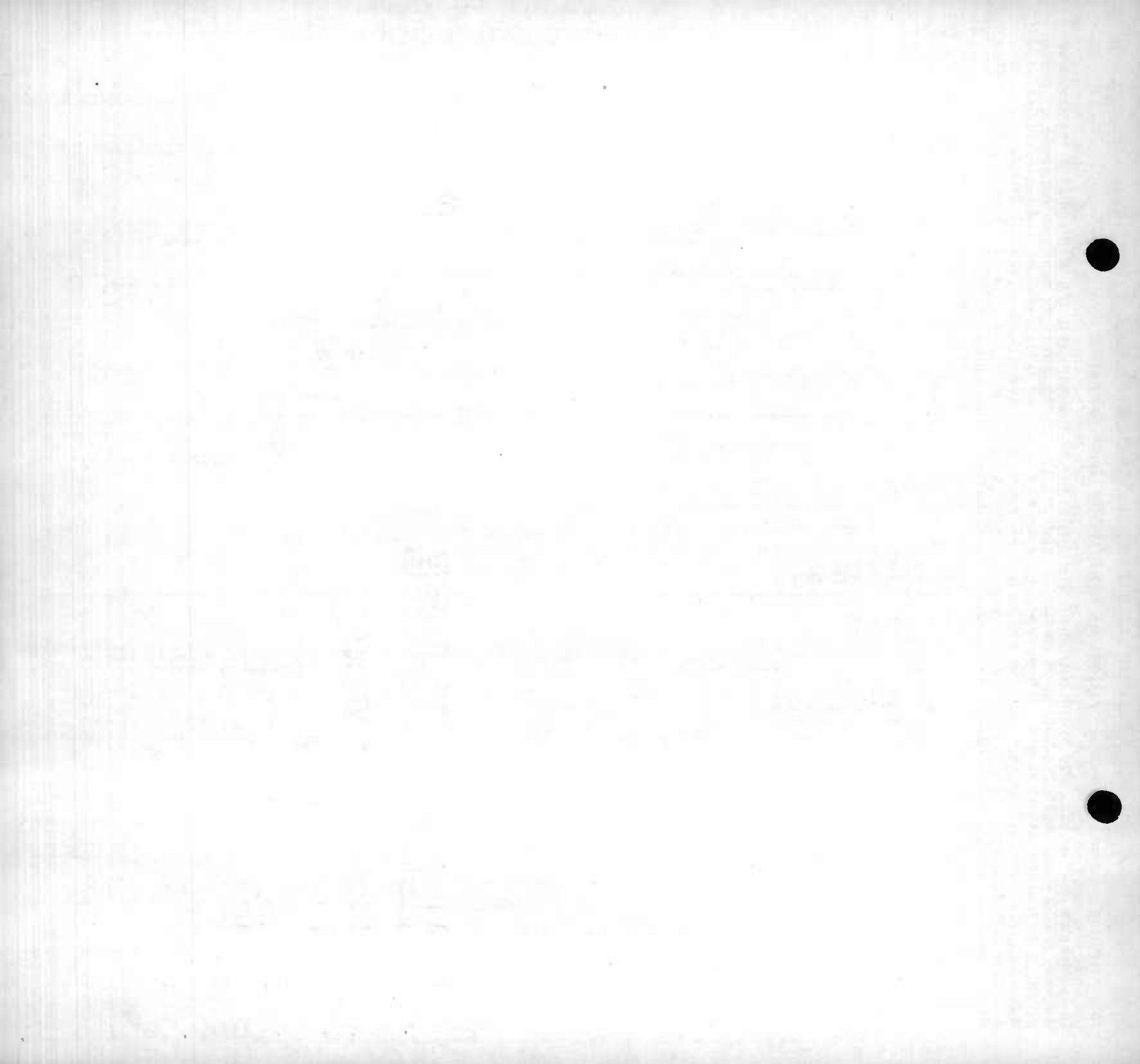
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12369	
BIRTH NO. 66 12369		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>MYRTLE SASON</i>		2. DATE AND HOUR OF DEATH <i>12/7/66 7:30 P M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 Mercy Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>26-10 121 N. Clinton Street</i>			
5. SEX <i>W</i>	6. RACE <i>F</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>4/23/1894</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
13. FATHER'S NAME <i>William Chival</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Pearman</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-05-0394</i>		17. INFORMANT <i>Mrs. Violet Richter 107 N. Clinton St</i>	
18. <i>155-1-1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>CARCINOMA OF THE GALLBLADDER WITH METASTASES</i> (B) <i>CHOLELITHIASIS</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>MONTHS</i> <i>YEARS</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>9/1/66</i> to <i>12/7/66</i> , that (1) (we) last saw the deceased alive on <i>12/7/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>L. Bruce Gerber, M.D.</i>		23B. DATE SIGNED <i>12/8/66</i>		23C. PHYSICIAN'S NAME (Type) <i>S. BRUCE GERBER</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/10/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR <i>3000 E. Baltimore St.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25D. ADDRESS <i>3000 E. Baltimore St.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12370	
BIRTH NO. 66 12370		MAY 1940		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary E. Doyle		2. DATE AND HOUR OF DEATH 12/8/66 17.30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) N. CHARLES STR. GEN. HOSPITAL			A. STATE Md. B. COUNTY		
5. SEX F.			6. RACE W.		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH 5/26/182		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			11. BIRTHPLACE (State or foreign country) GERMANY		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? AMERICAN		
13. FATHER'S NAME STEPHEN WALDSACHS			14. MOTHER'S MAIDEN NAME JOHANA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-07-8457		
17. INFORMANT DR. ROUBENOFF			ADDRESS N. Charles G. Voght		
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) ARTERIOSCLEROTIC HEART DISEASE YEARS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(B) DUE TO		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11/1/66 19 to 12/8/66 19			that (I) (we) last saw the deceased alive on 12/8/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Robert Roubenoff			23B. DATE SIGNED 12/8/66		
23C. PHYSICIAN'S NAME (Type) ROBERT ROUBENOFF			23D. ADDRESS N. CHARLES GEN. HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12/12/66		
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
25C. FUNERAL DIRECTOR John A. Moran, Inc.			ADDRESS 3000 E. Baltimore St.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12371	
BIRTH NO. 66 12371		CERTIFICATE OF DEATH		Registered No. 66 12371	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Sebastiana Frank Sessa</i>		2. DATE AND HOUR OF DEATH <i>December 9, 1966 6:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 136 N. Decker Avenue</i>		A. STATE <i>Maryland</i> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 6-61</i>	
		D. STREET ADDRESS (If rural, give location) <i>136 N. Decker Avenue</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>4/1/1885</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Baltimore City Hospital</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Peter Sessa</i>		14. MOTHER'S MAIDEN NAME <i>Roselli Castro</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>Mrs. Theresa B. Sessa 136 N. Decker Ave.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>204.01</i>		CAUSE OF DEATH (A) <i>Chronic Lymphatic Leukemia</i> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>5 Yrs</i>	
19. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>19 50</i> to <i>12/9</i> 19 <i>66</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>12/1</i> 19 <i>66</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Sidney D. Kreider</i>		23B. DATE SIGNED <i>12/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. Sidney D. Kreider</i>		23D. ADDRESS <i>4940 Eastern Avenue Baltimore, MD 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12/13/1966</i>	24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1966</i>	25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran Inc. 3000 E. Baltimore St.</i>			

Chemical Engineering

2nd Year

15/10

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1-10/10

Part 1, 2nd Year



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 12372	
BIRTH NO. 66 12372				Registered No. 66 12372	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>Salvatore Culotta</b>				2. DATE AND HOUR OF DEATH <b>Dec. 14, 1966</b> <b>6 05</b> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Baltimore City</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hospital</b> <b>43</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>24-03</b>	
				D. STREET ADDRESS (If rural, give location) <b>1422 Battery Avenue</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>2-6-1885</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>					
13. FATHER'S NAME <b>Stephen Anthony Culotta</b>				14. MOTHER'S MAIDEN NAME <b>Josephine La Martina</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Salvatore Culotta 1437 Hull St.</b>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>422.1 I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p><b>Arteriosclerotic cardiovascular disease</b></p> <p>(A) DUE TO</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div style="width: 50%;"> <p><b>Pneumonia</b></p> </div> </div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Tsung-jen Huang</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12 11 66</b>		24C. NAME of CEMETERY or CREMATORY <b>Cathedral</b>	
24D. LOCATION <b>Balto. Md.</b>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <b>Robert E. Farley</b>	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR <b>Mc Cully</b>	
24J. DATE REC'D BY HEALTH DEPT.		24K. NAME OF REGISTRAR		24L. ADDRESS <b>130 E. Fort Ave</b>	

2nd Baltimore General Hospital

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W

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Anthony

Italy

2-6-1917

19

1st Baltimore General Hospital

Baltimore

1st Baltimore General Hospital

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No.	
BIRTH NO.		66 12373		66 12373	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
McCANN, BETTY G.			12/5/66 7 30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
UNIVERSITY Hospital BALTO. MD.			A. STATE MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTO. MD. 26-44		
			D. STREET ADDRESS (If rural, give location)		
			3526 E. BALTIMORE ST.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	B. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.
F	white	Married	9/17/23	43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)	
LABOR		EASTERN? VEGETARIAN BLIND CO INC		MARYLAND	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
ANTHONY CLUPP			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			217-14-4459		PATIENT'S CHART
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			(A) SEPTICEMIA		
ANTECEDENT CAUSES			(B) PROBABLY 2° Urinary Tract Infection		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II			DECOMPENSATED LAENNEC'S CIRRHOSIS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/18 1966 to 12/5 1966, that (I) (we) last saw the deceased alive on 12/5 1966 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Irvin M. Sopher				12/5/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
IRVIN M. SOPHER				UNIVERSITY Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		DEC 9 66		ST PAUL'S CEMETERY	
				5600 CARDIFF AVE MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 12 1966		Robert E. Farber		DIPPEL BROTHERS INC 1800 E. Lombard ST	

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BR 1110 12 1961

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BR 1110 12 1961

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 12374					66 12374				
BIRTH NO.					Registered No.				
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>James K. Mills</b>					<b>2. DATE AND HOUR OF DEATH</b> <b>December 9, 1966</b>   <b>5 A.</b> <span style="float: right;">M.</span>				
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <b>832 Powers St.</b> </div> <div> <b>(If not in hospital or institution, give street address or location)</b> </div> </div>					<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b> <b>Baltimore</b> <span style="float: right;"><b>13-06</b></span> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>D. STREET ADDRESS</b> (If rural, give location) <b>832 Powers St</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Aug 23, 1900</b>	<b>9. AGE</b> (In years last birthday) <b>66</b>	<b>If Under 1 Yr.</b> <b>Months</b> <b>Days</b>	<b>If Under 24 Hrs.</b> <b>Hours</b> <b>Min.</b>	<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Koppers Co</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Kentucky</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>			
<b>13. FATHER'S NAME</b> <b>George Mills.</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Eva ?</b>				
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b> <b>6/27/25</b>			<b>16. SOCIAL SECURITY NO.</b> <b>?</b>		<b>17. INFORMANT</b> <b>Cora Mills. 832 Powers St.</b> <b>ADDRESS</b>				
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					<b>CAUSE OF DEATH</b> <b>(A) DUE TO</b> <i>Diffuse Pulmonary Emphysema</i> <i>Chronic Bronchitis</i> <b>10 yrs.</b> <b>(B) DUE TO</b> <b>(C)</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)					
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>					
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>11 - 26</b> <b>19 57</b> <b>to</b> <b>12 - 9</b> <b>19 66</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>12 - 8</b> <b>19 66</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>									
<b>23A. SIGNATURE</b> <i>William P. Benson, Jr.</i> <b>M.D.</b>					<b>Attending Phys.</b> <input checked="" type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/>		<b>23B. DATE SIGNED</b> <b>12-9-66</b>		
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>WILLIAM P. BENSON, JR.</b> <b>M.D.</b>					<b>23D. ADDRESS</b> <b>3506 N. Calvert St. Balt., Md.</b>				
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>12/12/66</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Balto National</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Frederick Rd, Md</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Taylor, M.D.</i>		<b>25C. FUNERAL DIRECTOR</b> <i>Justin E. Donovan</i>		<b>ADDRESS</b> <b>3818 Roland Ave</b>			

UNITED STATES

THE POWER OF

and S. J. P. M.

W. J. P. M.

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 12375	
BIRTH NO. 66 12375		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PERKINS, BESSIE MAY		2. DATE AND HOUR OF DEATH 5 DEC 1966 8:14 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSP.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MD. 27-09			
		D. STREET ADDRESS (If rural, give location) 1555 NORTHWOOD ROAD			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-23-1887 12-5-66	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES E. YORK		14. MOTHER'S MAIDEN NAME JOSEPHINE GARRETT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. unk		17. INFORMANT ADDRESS Grace P. Jenkins - 1555 Northwood Rd	
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral hemorrhage DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 hr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5 DEC 1966 to 5 DEC 1966, that (1) (we) last saw the deceased alive on 5 DEC 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.					
23A. SIGNATURE Sidney E. Kirkley		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5 Dec 66	
23C. PHYSICIAN'S NAME (Type) DR. SIDNEY E. KIRKLEY		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-66		24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 12 1966			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS John C. Miller Inc 6415 Belair Road-21206			

POKING FINGER

2 DEC 1960

2/11

Union Memorial Hosp

1225 NORTHWOOD ROAD  
BALTIMORE, MD  
M6 BATTMOR

F W WIDOWED

12-2-60 29

HOMEMAKER

MARYLAND

CHARLES E. YORK

TOTOPHINE CARPENT

NO

1

Central Maryland

8 hr

NO

Anthony E. Kelly

2 DEC 60

2 DEC 60

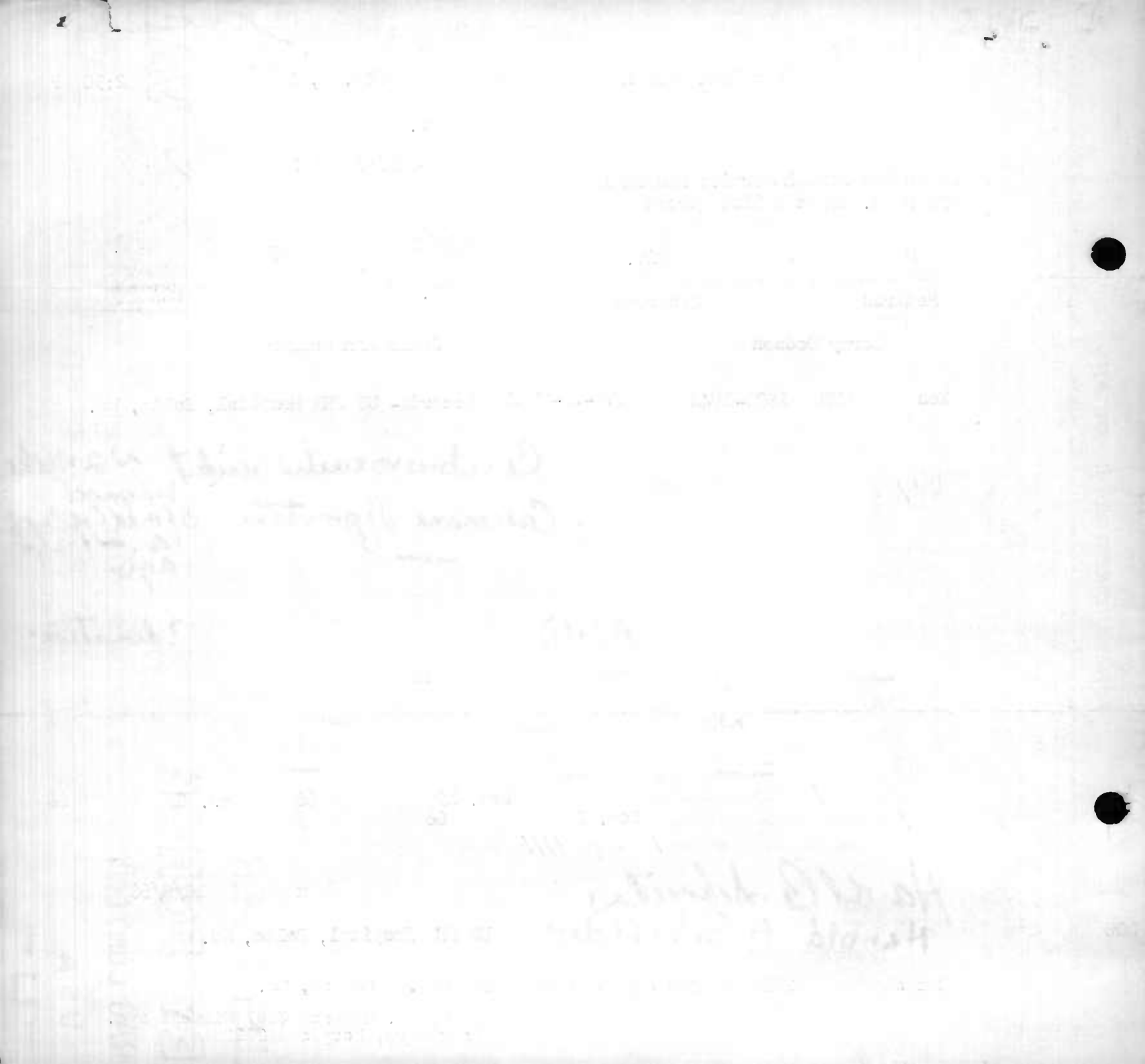
2 DEC 60



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

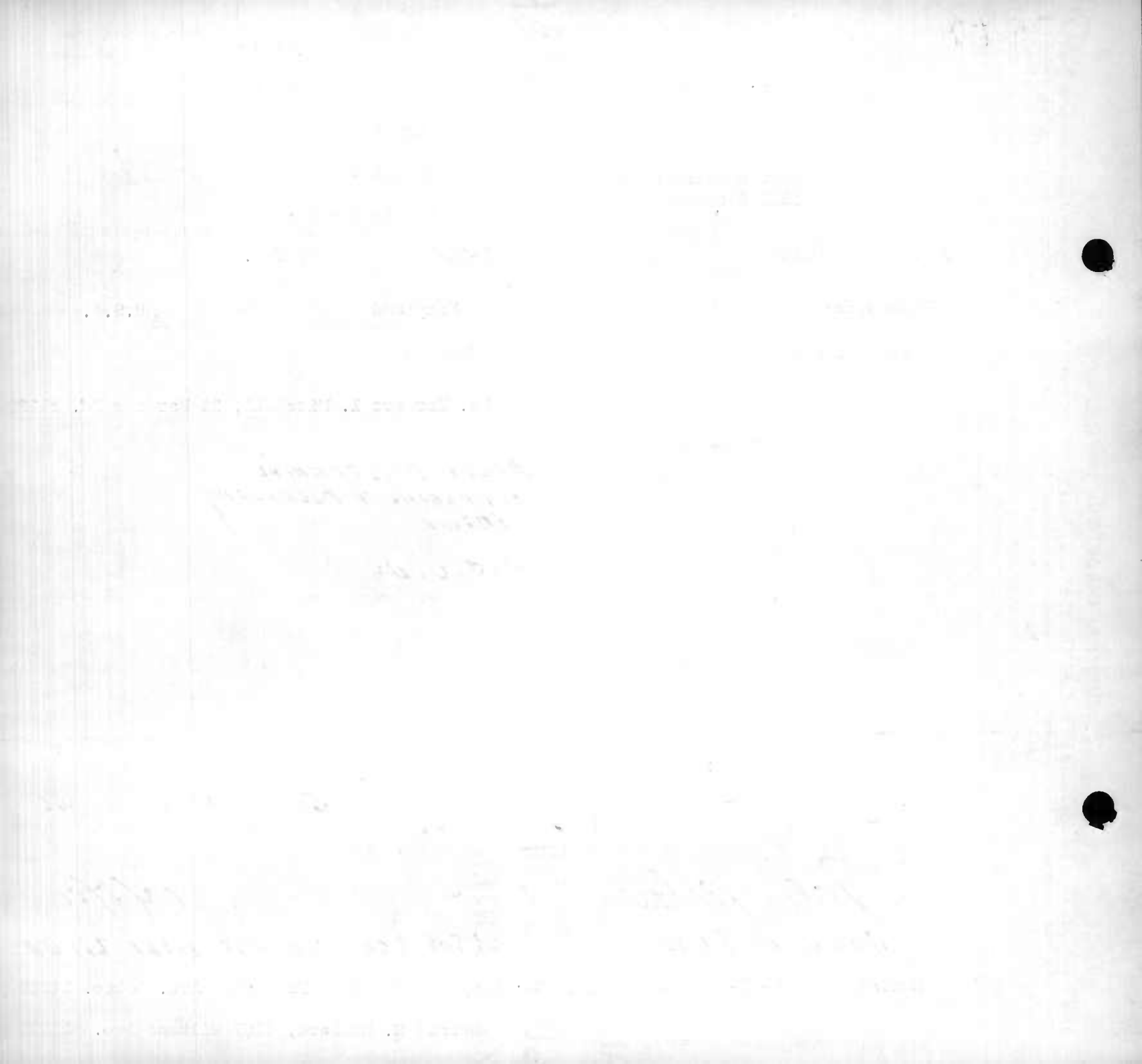
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12376</b>	
BIRTH NO. <b>66 12376</b>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Eppa Lott Dodson</b>		2. DATE AND HOUR OF DEATH <b>Dec. 8, 1966</b> <span style="float: right;"><b>2:30 P M.</b></span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Va.</b> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Colonial Beach</b> <span style="float: right;"><b>V-43</b></span>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital Wyman Pk. Drive &amp; 31st Street</b>		D. STREET ADDRESS (If rural, give location)		5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Div.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Seafarer</b>		8. DATE OF BIRTH <b>9/2/81</b> 9. AGE (In years lost birthday) <b>85</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Leroy Dodson</b>	
14. MOTHER'S MAIDEN NAME <b>Julia Ann Walker</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes SUN 1939-1944</b>		16. SOCIAL SECURITY NO. <b>578-12-7764</b>	
17. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b>		ADDRESS		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular accident ~ 2 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Diagnosed at Med College Va. ~ 1-2 yrs ago</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASND</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		20. AUTOPSY? (Yes or No) <b>no</b>		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 15</b> 19 <b>66</b> to <b>Dec. 8</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec. 8</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold A. Schneider</b> M.D.				23B. DATE SIGNED <b>12/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Harold A. Schneider</b> M.D.				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bethany Baptist Church Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Callao, Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>\$107 Wilkens ave. Baltimore, Maryland 21229</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-640		BIRTH NO. 66 12377		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 12377	
1. NAME OF DECEASED (Type or Print) <b>Helen J. Brolle</b>				2. DATE AND HOUR OF DEATH <b>December 8, 1966</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 Hood Nursing Home 5213 Edmondson Avenue</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>21 Mardrew Road</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>2-21-1889</b>	9. AGE (In years last birthday) <b>77 Yrs.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Charles Coale</b>				
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Mr. Herbert I. Mitchell, 21 Mardrew Rd. 21229</b>				
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION &amp; PULMONARY EMBOLISM</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>D.C.U.D.</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/1</b> 19 <b>66</b> to <b>12/8</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John H. Shaw</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>John H. Shaw</b>				23D. ADDRESS M.D. <b>5800 Edmondson Ave. Balt. 28, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-12-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>3801 Frederick Ave. Balto. 21229</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12378</span>	
BIRTH NO. <span style="float: right;">66 12378</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>HERMAN ROSEN KILDE</i>		2. DATE AND HOUR OF DEATH <i>12-10-66 12:35 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>35 Church Home Hospital</i>		A. STATE <i>M.D.</i> B. COUNTY <i>Baltimore Co.</i>		C. CITY OR TOWN <i>Essex (21)</i> (If outside city limits, write RURAL and give township) <i>53-00</i>	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>81 SILVER LAKE Rd.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>11-23-93</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Beth Steel</i>		11. BIRTHPLACE (State or foreign country) <i>DENMARK</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Richard Rosenkilde</i>		14. MOTHER'S MAIDEN NAME <i>CHRISTINE HERMANSON</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-07-9982</i>		17. INFORMANT ADDRESS <i>Marie Rosenkilde Same</i>	
18. <i>378X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Generalized Septicemia</i> (B) DUE TO <i>Perforated Sigmoid colon</i> (C) <i>Colon</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Prolonged Heart Failure</i>			
19A. DATE OF OPERATION <i>12-8-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>perforated bowel</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 8-</i> 19 <i>66</i> to <i>Dec. 10</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>12-10</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Asst. Emb.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-10-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Raymond Atkins</i>		M.D. ADDRESS <i>Church Home Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12/13/66</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Co., Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Farkas</i>		25C. FUNERAL DIRECTOR ADDRESS <i>James Bruzdinski Bruzdinski Funeral Home 1407 Eastern Ave.</i>	

How much over time

M.D.

Church Home Hospital  
at 214 Ave. 100

11-22-23 73

M

M

Beth Steel

Concord

Richard Rosenkild

Demmer

Christine Heanwood

213-02-0000

Prescribed 2 capsules  
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Prescribed 2 capsules  
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12-8-21

12-10-21

12-10-21

12-10-21

Dr. Eugene Atkins  
Caretaker

Church Home Hospital

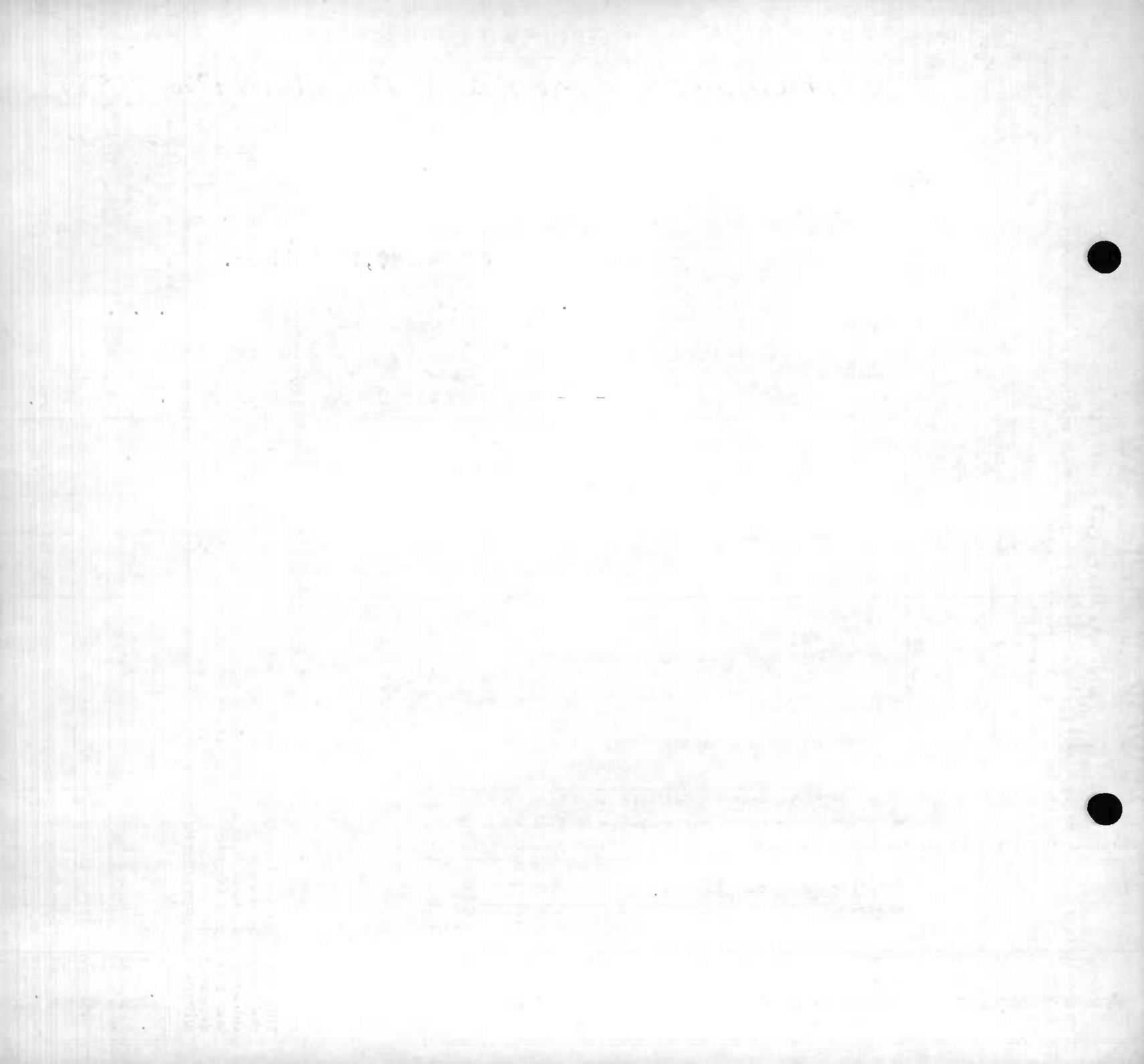
12-10-21

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 12379</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12379</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Catramados, Eugenia</b>		2. DATE AND HOUR OF DEATH <b>December 9 1966 7:58 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hosp</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b> B. COUNTY <b>23-01</b>	
5. SEX <b>F</b>		6. RACE <b>W.</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	
8. DATE OF BIRTH <b>JANUARY 20, 1900</b>		9. AGE (In years last birthday) <b>66 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Sparta Greece</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Calavetinos</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Porter Charuhas</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>212-28-1987</b>	
17. INFORMANT <b>Stratis Catramados</b>		ADDRESS <b>1226 S. Charles St.</b>		18. <b>600.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) <b>Chronic pyelonephritis</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that <del>this</del> (this hospital) attended the deceased from <b>12-1</b> 19 <b>66</b> to <b>12-9</b> 19 <b>66</b> , that <del>we</del> (we) last saw the deceased alive on <b>12-9</b> 19 <b>66</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Tsang-jen Huang</b>	
23B. DATE SIGNED <b>12-10-66</b>		23C. PHYSICIAN'S NAME (Type) <b>South Baltimore General Hospital</b>		23D. ADDRESS <b>Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/13/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Greek Orthodox Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>	
25C. FUNERAL DIRECTOR <b>KRAUSE FUNERAL HOME</b>		ADDRESS <b>1216 S. Charles St.</b>		VS 150-REV. 1/1/65	







66 12380

BALTIMORE CITY HEALTH DEPARTMENT

66 12380

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EDITH G. MILLER

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1966 5:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

309 Mason Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Aug. 11, 1890

9. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Own Home

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jordan

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Theodore Miller 1031 Middlesex Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Cranio-cerebral Injuries  
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Relative's Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

6317 Boston Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
12 9 '66 P m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☒NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Apparently fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-13-1966

23C. NAME of CEMETERY or CREMATORY

Cedar Hill

23D. LOCATION (City, town, or county) (State)

Anne Arundel County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 12 1966

Robert E. Fickel

Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.

WILLIAM B. FRODOFF

DEPARTMENT OF JUSTICE

UNITED STATES

*Robert M. Kennedy*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

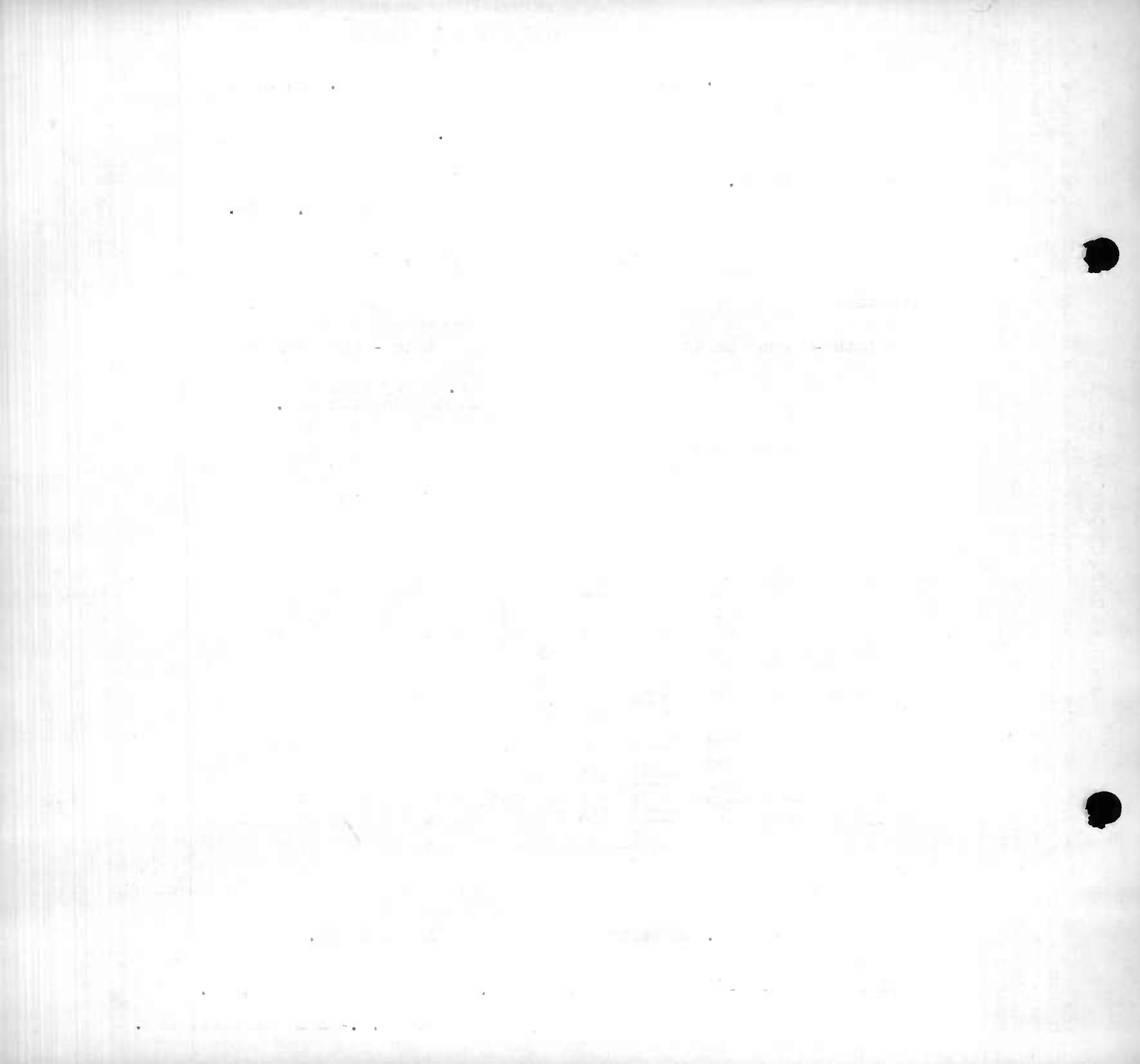
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. 66 12381						
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b> 10  <b>M.E. CASE NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <u>ANNA KOLB</u> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <u>12-11-66 10 20</u> <span style="float: right;">M. <u>A</u></span> </div> </div>											
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex;"> <div style="flex: 1;"> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <u>34 Bon Secours</u> </div> <div style="flex: 1;">                     (If not in hospital or institution, give street address or location)                 </div> </div>					<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) <div style="display: flex;"> <div style="flex: 1;"> <b>A. STATE</b>  <u>MD.</u> </div> <div style="flex: 1;"> <b>B. COUNTY</b>  <u>Balt. Co.</u> </div> </div>						
<b>5. SEX</b> <u>F</u> <b>6. RACE</b> <u>W</u> <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>widowed</u>					<b>8. DATE OF BIRTH</b> <u>2/15/1881</u>		<b>9. AGE</b> (In years last birthday) <u>79</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>					<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>BALTO.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>JOHN H. BSCAMAN</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>MRS. ANNE HESSING</u>						
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs. Jean Connolly</u>			<b>ADDRESS</b> <u>404 Greenlow Rd.</u>	
<b>18. CAUSE OF DEATH</b> <div style="display: flex;"> <div style="flex: 1;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <u>293 XI</u> </div> <div style="flex: 1;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>9-10 AM</u> </div> </div>											
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="display: flex;"> <div style="flex: 1;"> <u>(A) Anemia</u>  <u>(B) Chronic pyelonephritis + art. nephrosclerosis</u>  <u>(C) Arteriosclerotic cardiovascular disease</u> </div> <div style="flex: 1;"> <u>Pulmonary hypertension</u> </div> </div>											
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <u>None</u>											
<b>MEDICAL CERTIFICATION</b> <div style="display: flex;"> <div style="flex: 1;"> <b>19A. DATE OF OPERATION</b>  <u>2</u> </div> <div style="flex: 1;"> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  <u>None</u> </div> <div style="flex: 1;"> <b>20A. AUTOPSY?</b> (Yes or No)  <u>Yes</u> </div> <div style="flex: 1;"> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>  <u>Yes</u> </div> </div>											
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>					<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>						
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)					<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
<b>21F. HOW DID INJURY OCCUR?</b>					(If in Baltimore City, give exact location)						
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec. 3</u> <u>1966</u> <b>to</b> <u>Dec. 11</u> <u>1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec. 11</u> <u>1966</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>											
<b>23A. SIGNATURE</b> <u>Nam Doan Yang</u> <span style="float: right;">M.D.</span>					<b>23B. DATE SIGNED</b> <u>Dec. 11, '66</u>						
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>NAM DOAN YANG</u> <span style="float: right;">M.D.</span>					<b>23D. ADDRESS</b> <u>Bon Secours Hospital</u>						
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>12-14-66</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>New Cathedral Cem.</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>					
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 12 1966</u>					<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Johnson</u>						
<b>25C. FUNERAL DIRECTOR</b> <u>Witzke F.D.-4101</u>					<b>ADDRESS</b> <u>Edmondson Ave.</u>						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12382</b>	
BIRTH NO. <b>66 12382</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Elizabeth V. Kelly</b>		2. DATE AND HOUR OF DEATH <b>Dec. 11, 1966</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>5004 Parkton St.</b>		A. STATE <b>Md.</b> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>5004 Parkton St. Ave.</b>			
5. SEX <b>F</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 18, 1880</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Late - John Phelan</b>		14. MOTHER'S MAIDEN NAME <b>Late - Mary Knight</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Harry Phelan</b> <b>1406 Edmondson Ave.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CORONARY OCCLUSION - MYOCARDIAL INFARCTION</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>2 MIN.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>ATHEROSCLEROTIC CV DISEASE</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>NOV. 16</b> 19 <b>62</b> to <b>DEC 11</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>DEC. 7</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>John F. Schaefer</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>DEC. 12 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>John F. Schaefer</b>		23D. ADDRESS <b>401 Random Rd.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-14-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltner</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D.</b>	
25D. ADDRESS <b>4101 Edmondson Ave.</b>					



66 12383

BALTIMORE CITY HEALTH DEPARTMENT

66 12383

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES Joseph WATERS

2. DATE AND HOUR PRONOUNCED DEAD

December 11, 1966 5:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Howard Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

RURAL Ellicott City

D. STREET ADDRESS (If rural, give location)

Bethany Lane

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 16, 1926

9. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

General Motors

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Late - James Waters

14. MOTHER'S MAIDEN NAME

Catherine McDonnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Audrey Waters

ADDRESS

Bethany Lane - Ellicott City

18. 422.1 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/11/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-14-66

23C. NAME of CEMETERY or CREMATORY

St. Alphonsus Cem.

23D. LOCATION

(City, town, or county)

Woodstock-Balto., Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

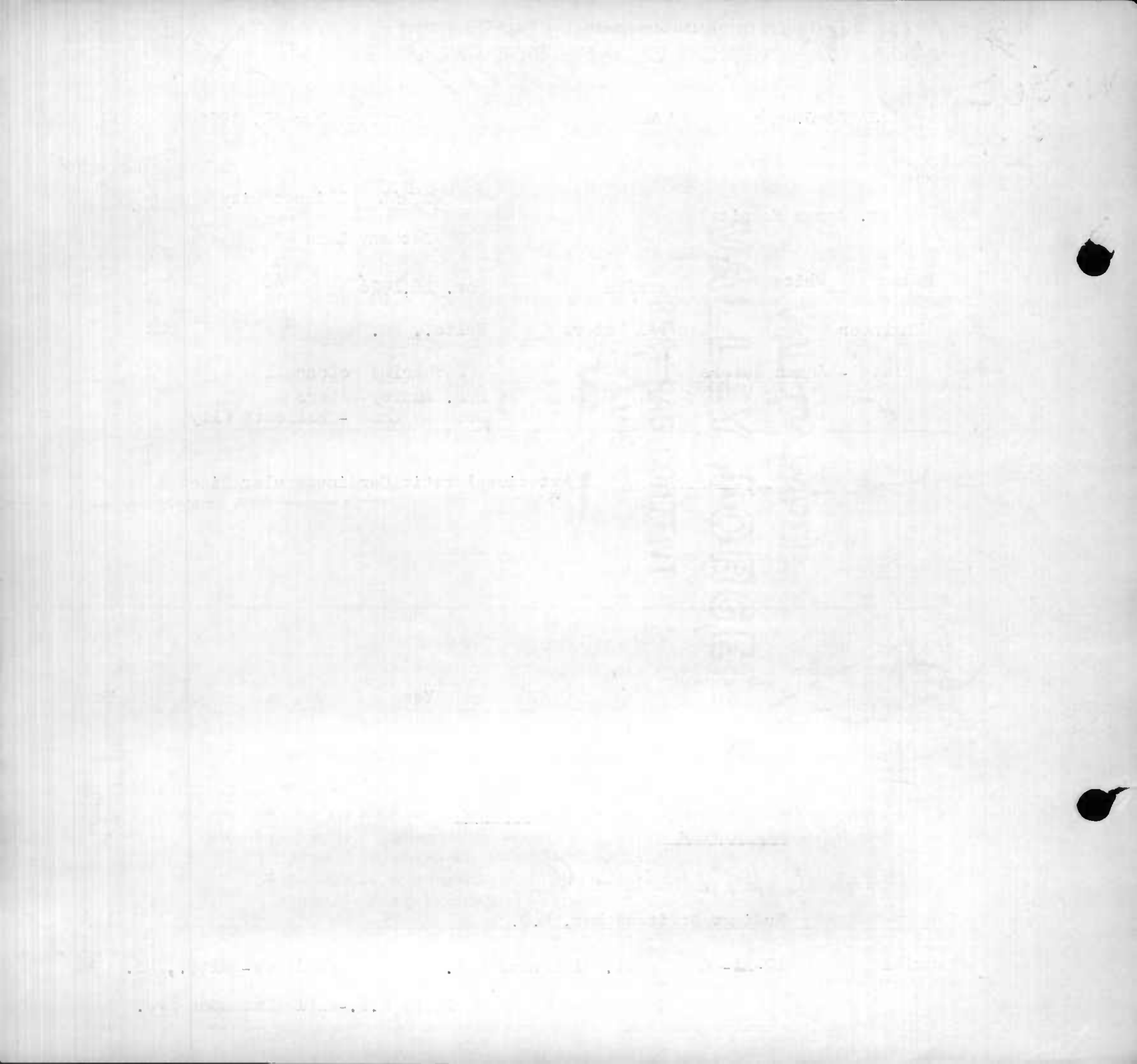
24C. FUNERAL DIRECTOR

ADDRESS

DEC 12 1966

Robert E. Taylor, M.D.

Witzke F.D., 4101 Edmondson Ave.

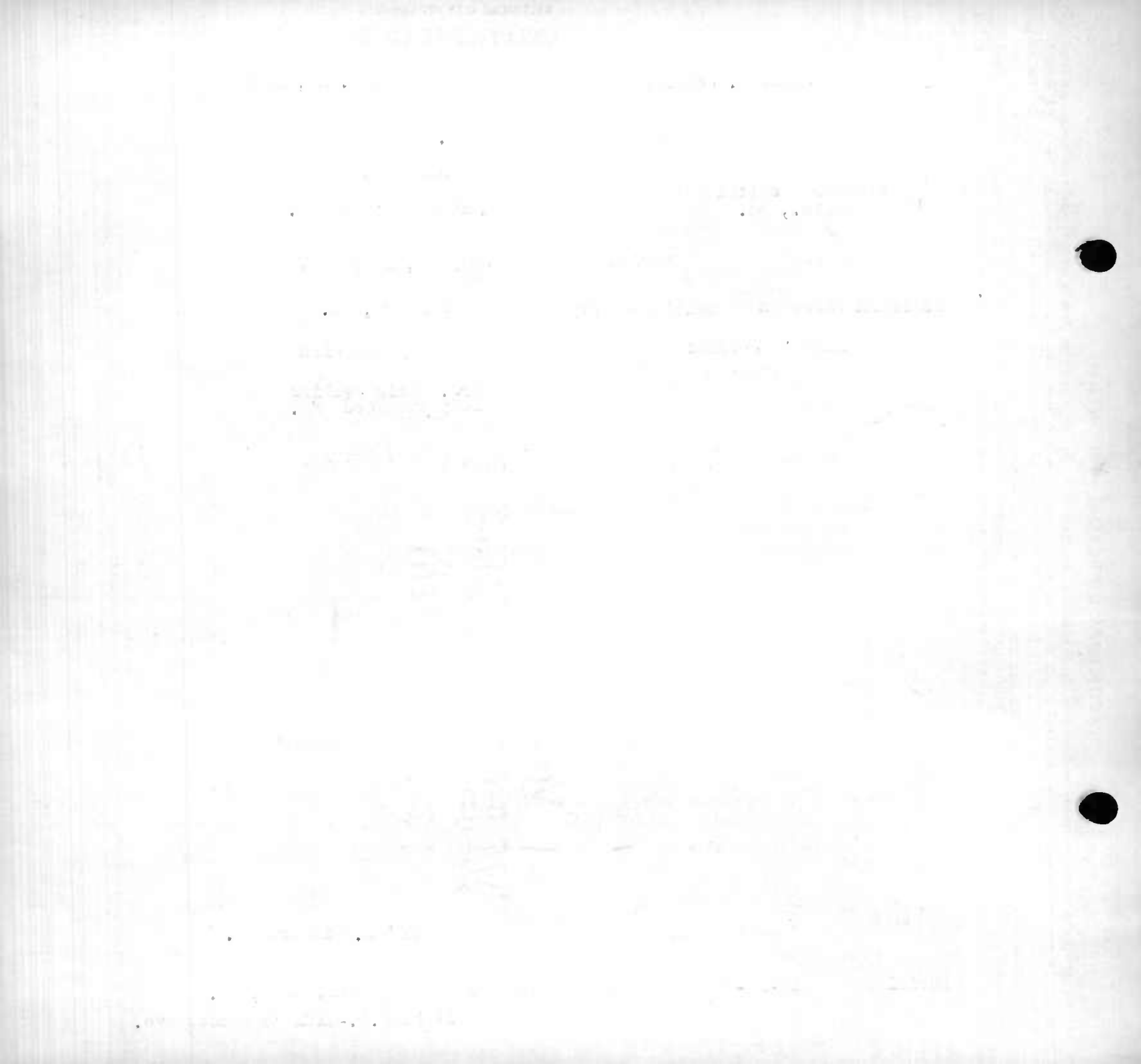




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 12384	
CERTIFICATE OF DEATH				Registered No. 66 12384	
BIRTH NO. 66 12384		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		James W. Jenkins		2. DATE AND HOUR OF DEATH Dec. 10, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  46 Lutheran Hospital Balto., Md.		A. STATE Md. B. COUNTY Baltimore, Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. D. STREET ADDRESS (If rural, give location) 1025 Stamford Rd.			
5. SEX M	6. RACE Wh	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 28, 1899	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <del>Fireman</del> Policeman		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Jenkins			14. MOTHER'S MAIDEN NAME Mary Ann Finn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Marie Jenkins 1025 Stamford Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11x260x ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes, stroke - Wilroy		CAUSE OF DEATH 1A. DUE TO Cerebral myocardial infarction 1B. DUE TO ACVD 1C. DUE TO ACVD		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 3 mo years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb. 1966 to 12/10 1966, that (I) (we) last saw the deceased alive on 12/10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE George Vash				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) George Vash		23D. ADDRESS 206 S. Gilmore St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-66		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore, Md.		24E. NAME of CEMETERY or CREMATORY Baltimore National		24F. LOCATION Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Witzke F.D. - 4101 Edmondson Ave.	



D-160

66 12385

BALTIMORE CITY HEALTH DEPARTMENT

66 12385

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DOROTHY T. DIVER

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1966

7:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21205

D. STREET ADDRESS (If rural, give location)

2034 E. Eager Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
single

8. DATE OF BIRTH

Sept. 22. 1895

9. AGE (In years  
lost birthday)

71

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)  
Nursing, Hospital.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

John A. Diver

14. MOTHER'S MAIDEN NAME

Mary Oertel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

220-30-0660-A

17. INFORMANT

Mrs. Doris Sargent

ADDRESS

2034 E. Eager St. Baltimore 21205

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)Hypertensive and arteriosclerotic  
cardiovascular disease(A) \_\_\_\_\_  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐  
m. WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Dec. 12. 1966

23C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 12 1966

24B. NAME OF REGISTRAR

Robert E. Feltner

24C. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.  
Baltimore Md.

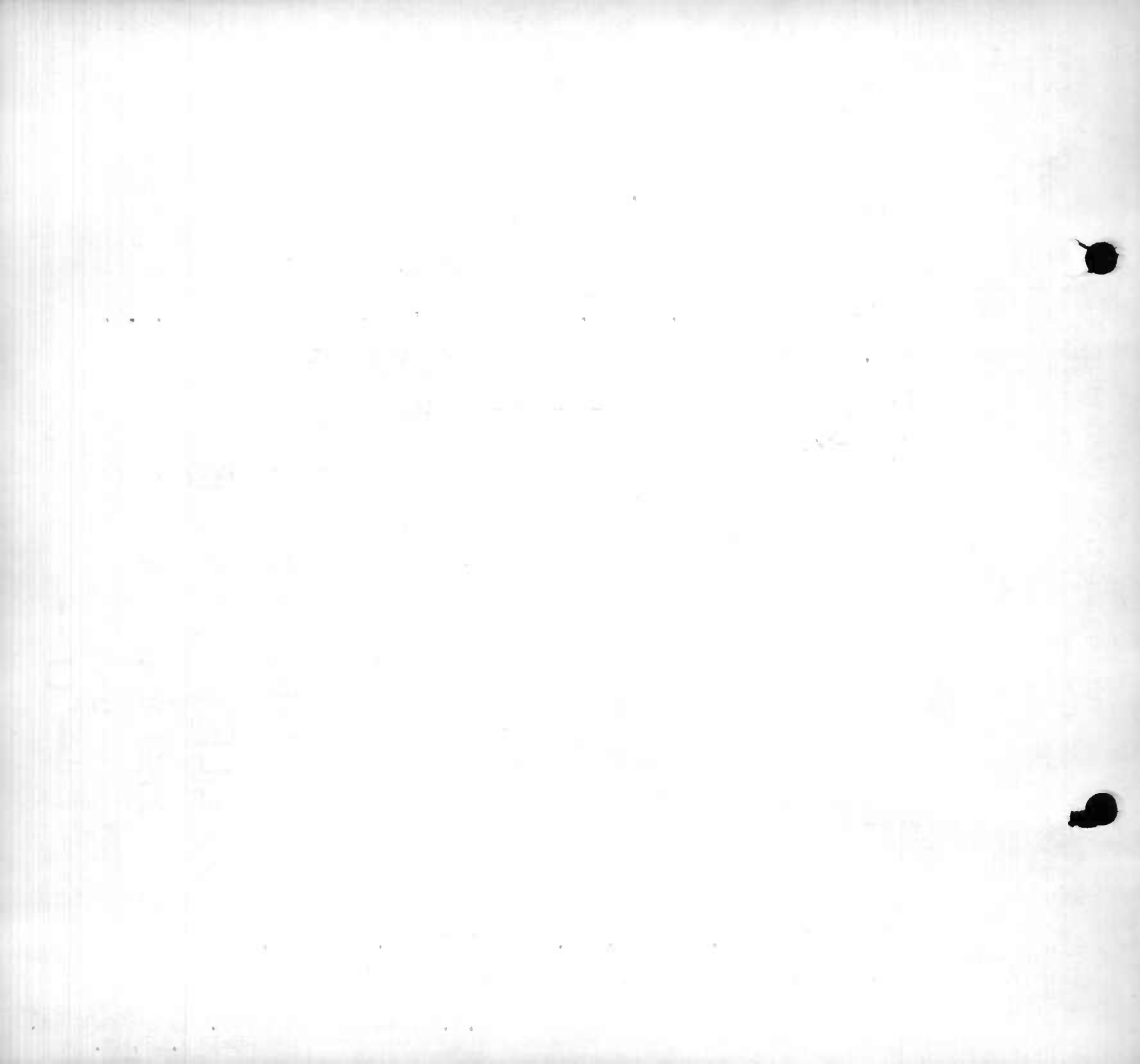
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12386				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12386	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Marie Frances Carlos				12-10-66		7 45 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
00		5600 Ready Ave.		Maryland		27-48	
5. SEX				6. DATE OF BIRTH			
F		W		5/1/1899		67	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
Single				Baltimore, Maryland		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired-Clerk				Fed. Gov't.		Baltimore, Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John M. Carlos				Christine Miller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				212-30-7094		Miss Agnes Carlos	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X I				(A) DUE TO		Cerebro-vascular hemorrhage sudden	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO		Hypertension arterio-sclerotic	
ANTECEDENT CAUSES				(C) DUE TO		Cardio vascular disease	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<input type="checkbox"/>							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 6-18 1960 to 12-10 1966, that (I) ( <del>we</del> ) last saw the deceased alive on 11-22 1966 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Alfred G. Ossman, Jr.				12-12-66.			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Alfred G. Ossman, Jr.				1010 St. Paul St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/13/1966		New Cathedral		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
DEC 12 1966		E. E. Talbot		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



1  
G 421

66 12387

BALTIMORE CITY HEALTH DEPARTMENT

66 12387

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DAVID R. GILLESPIE

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1966 7:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1824 Chilton Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/30/1908

9. AGE (In years last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Consultant

10B. KIND OF BUSINESS OR INDUSTRY

Metropolitan Insurance Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

David Gillespie

14. MOTHER'S MAIDEN NAME

Kathryn Hays

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL SECURITY NO.

212-09-2475

17. INFORMANT

Mrs. Falice M. Gillespie

ADDRESS

(Same)

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type)

ASSOCIATE MEDICAL EXAMINER ☐

December 9, 1966

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12/12/1966

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial Pk.

23D. LOCATION

Parkville, Balto. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 12 1966

24B. NAME OF REGISTRAR

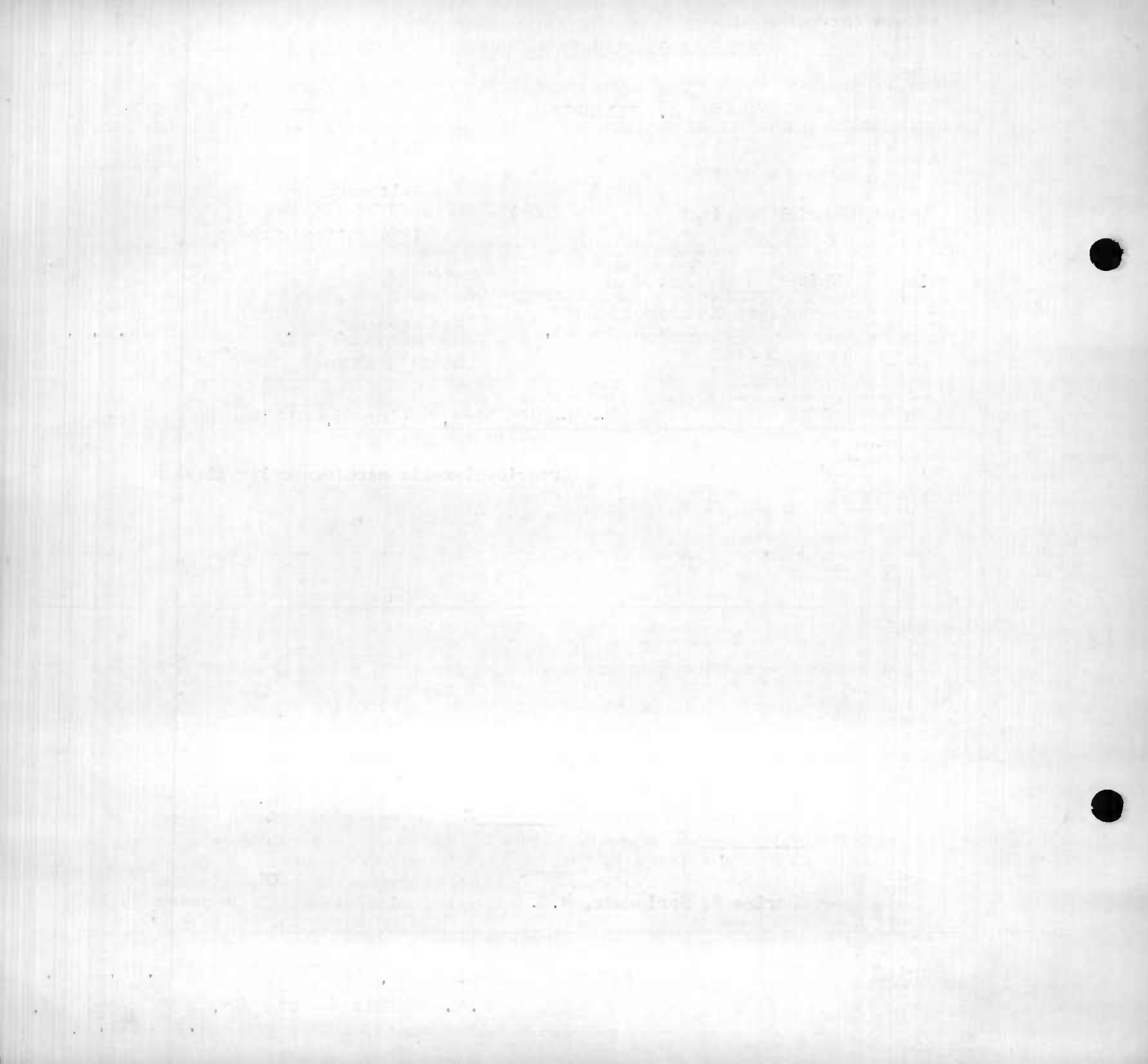
Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.

ADDRESS

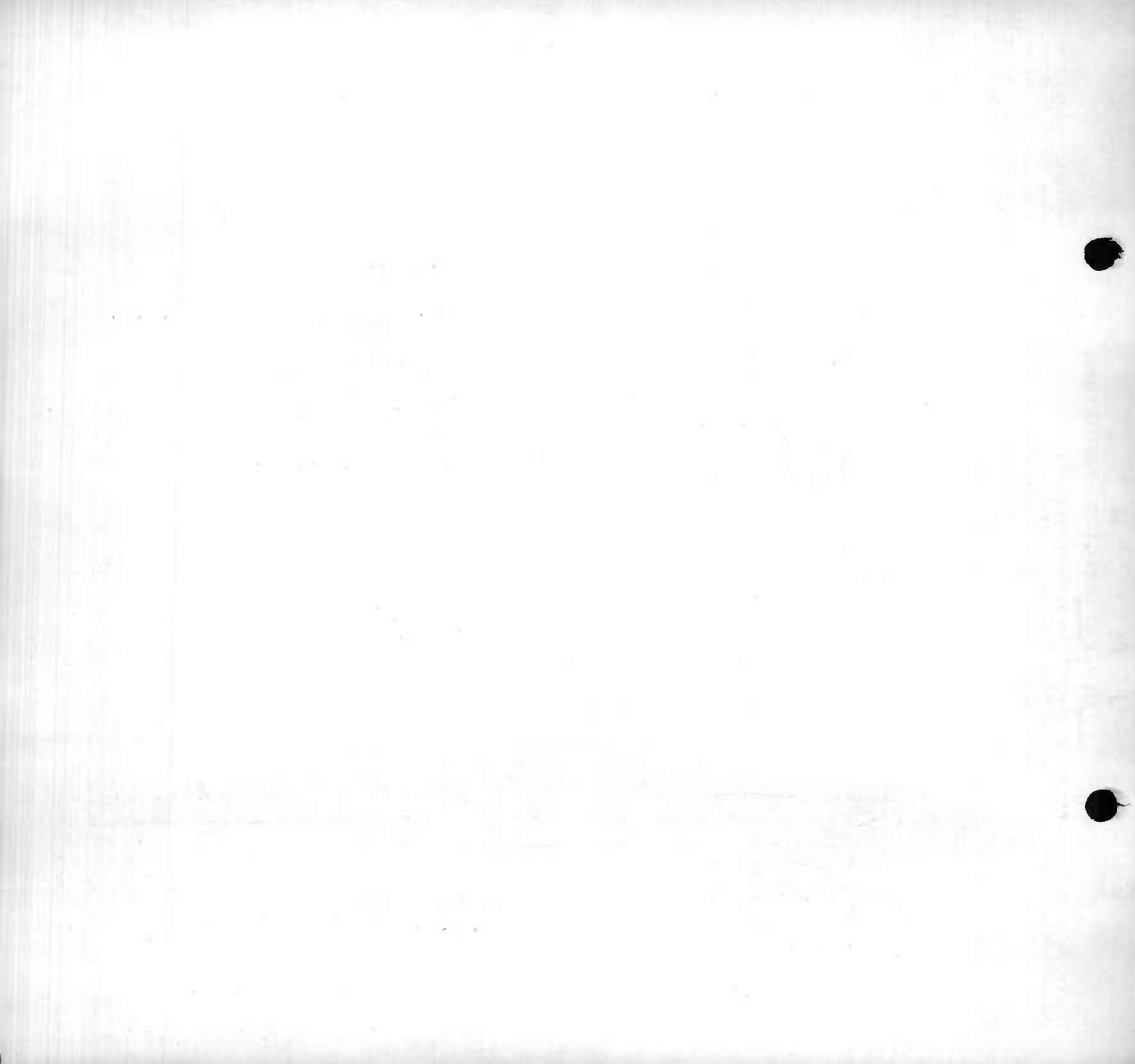
Balto. 12, Md.





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12388		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12388	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) RICHARD N. EDWARDS			2. DATE AND HOUR OF DEATH DEC. 9, 1966 5:10 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 700 HOMESTEAD STREET			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
D. STREET ADDRESS (If rural, give location) 700 HOMESTEAD STREET					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH SEPT. 23, 1886	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL CONSTRUCTION			11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ROBERT N. EDWARDS			14. MOTHER'S MAIDEN NAME KATE JONES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-10-2786	17. INFORMANT ADDRESS ANNA M. EDWARDS 700 HOMESTEAD ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 450.0 4260x Generalized Arteriosclerosis DUE TO			INTERVAL BETWEEN ONSET AND DEATH 3 years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Diabetes Mellitus 10 years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1956 19 to December 19 66, that (I) (we) lost saw the deceased alive on December 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/10/66
23C. PHYSICIAN'S NAME (Type) LOY M. ZIMMERMAN			23D. ADDRESS 3202 Hartford Rd, Baltimore, Md		
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) BURIAL DEC. 13		24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY		24D. LOCATION (City, town, or county) (State) PARKVILLE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1966		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR ADDRESS HENRY W. JENKINS & SONS CO 4905 YORK ROAD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12389		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12389	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Skrentny, Joseph</i>			12/10/66 3:40 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			D. STREET ADDRESS (If rural, give location) <i>3311 Beech Avenue</i>		
5. SEX <i>M.</i>	6. RACE <i>Caucasian</i>	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>01-31-97</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Attorney</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Law.</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>American</i>		13. FATHER'S NAME <i>Henry Skrentny</i>		14. MOTHER'S MAIDEN NAME <i>Cecilia Raby</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>219-07-8475</i>		17. INFORMANT <i>Mrs. M. Helene Muller</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>151X I</i>		CAUSE OF DEATH (A) DUE TO <i>① Carcinoma of stomach: with 1) perforation of stomach 2) peritonitis</i>		ADDRESS <i>3311 Beech Ave Baltimore, Md.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>② pulmonary Edema and Aspiration</i>		(B) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 hrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-05</i> 19 <i>66</i> to <i>12-10</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12-10</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hyong Sok Lee</i>				23B. DATE SIGNED <i>12-10-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>HYONG SOK LEE</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-13-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Stanislaus</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. LOCATION (State) <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Talbot</i>		25C. FUNERAL DIRECTOR <i>Wm. C. Brooks</i>	
				ADDRESS <i>1217 St Paul Street Baltimore Md.</i>	

345

15-10-10

20-03-10

Maryland

Baltimore

3311 Beach Avenue

01-31-10

American

Frederick Md

Carl's Box

0

M. Concession

Retired Attorney

Henry Skrentny

Yes

15-10-10

15-03-10

15-10-10

0

15-10-10

✓

Wesley Lee

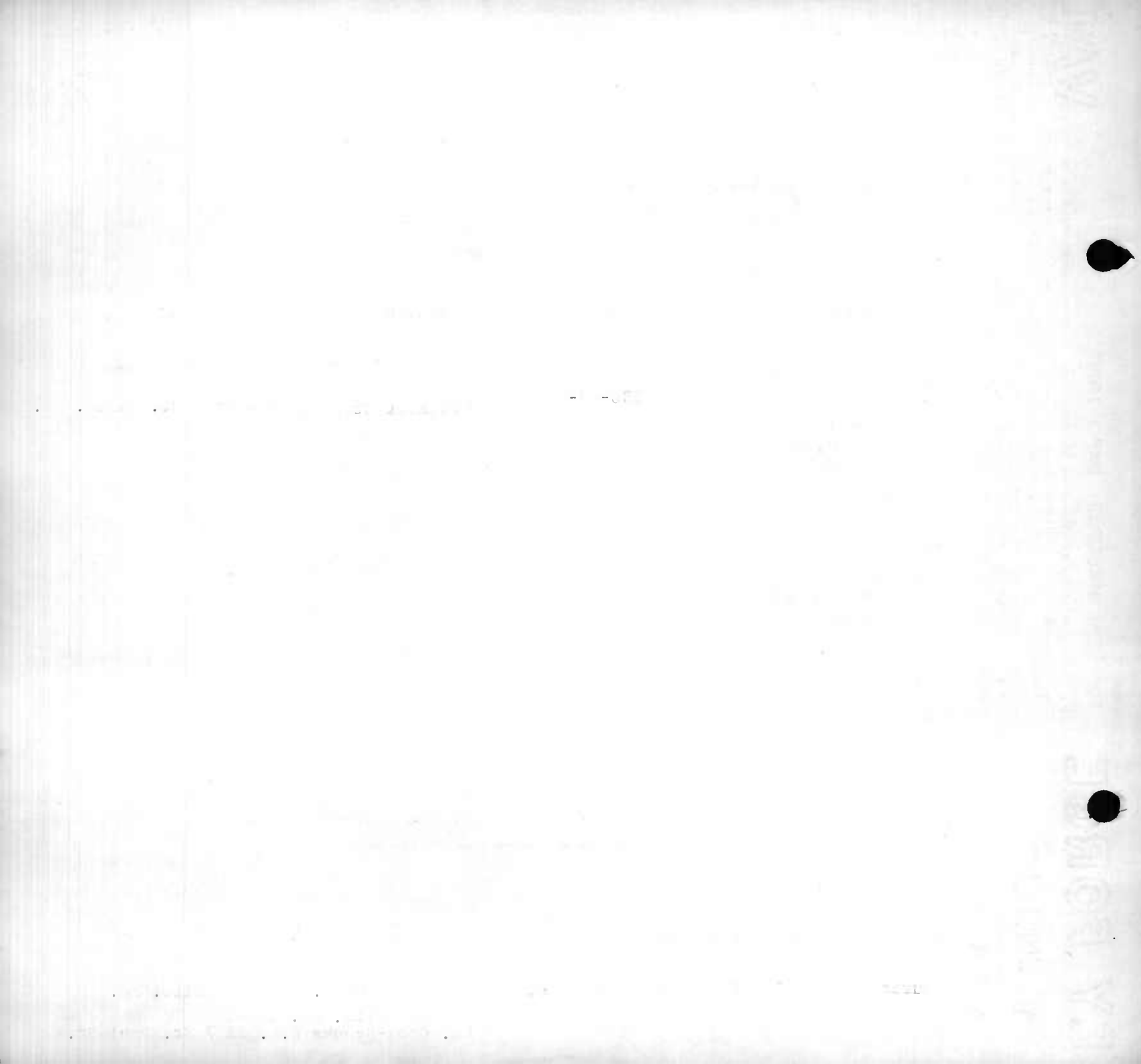
15-10-10

15-10-10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

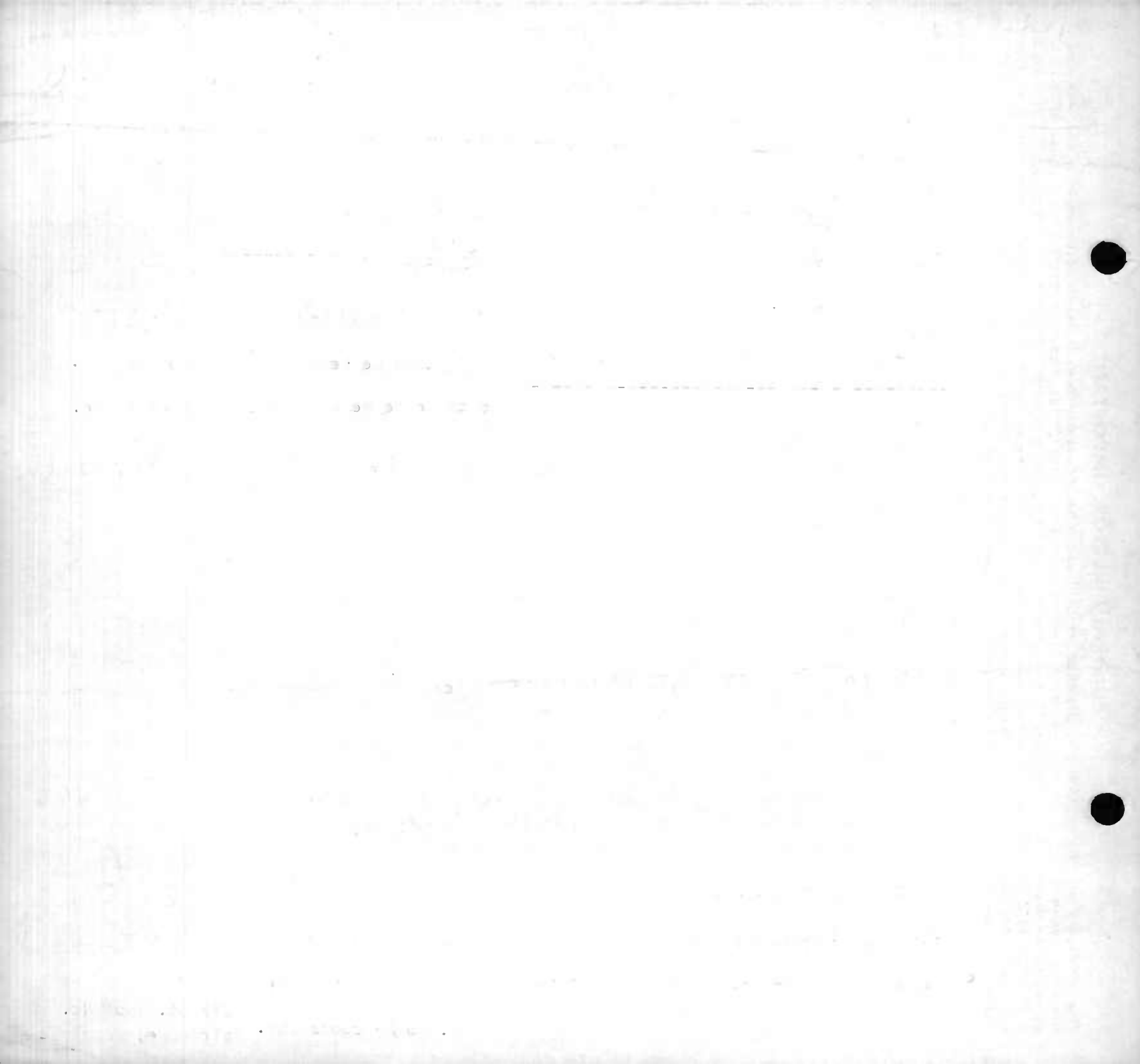
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>66 12390</b>		<b>CERTIFICATE OF DEATH</b>		66 12390	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Steffan, Louis F.</b>		2. DATE AND HOUR OF DEATH <b>12-9-66</b> <b>8:30</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hosp.</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>3-02</b> D. STREET ADDRESS (If rural, give location) <b>910 FAWN STREET</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4/10/90</b>	9. AGE (In years last birthday) <b>76</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Austria</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROMAN STEFFAN</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>238-03-9946</b>		17. INFORMANT <b>Margaret Steffan</b> ADDRESS <b>910 Fawn St. Balto. Md. #2</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>40 min</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>MYOCARDIAL INFARCT</b> DUE TO		<b>few days</b>	
		(C) <b>HYPERTENSION</b> DUE TO		<b>YRS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/9</b> <b>1966</b> to <b>12/9</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>12/9</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. Fishkin</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/9/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. FISHKIN</b>		23D. ADDRESS <b>BALTO, MD</b> <b>1111 - 605 N. BROADWAY</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/13/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Balto. County Balto. Md.</b>		24E. LOCATION (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>P. J. J. J.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md. 21202</b> <b>Wm. Cook-Brooks F.H. 1217 St. Paul St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

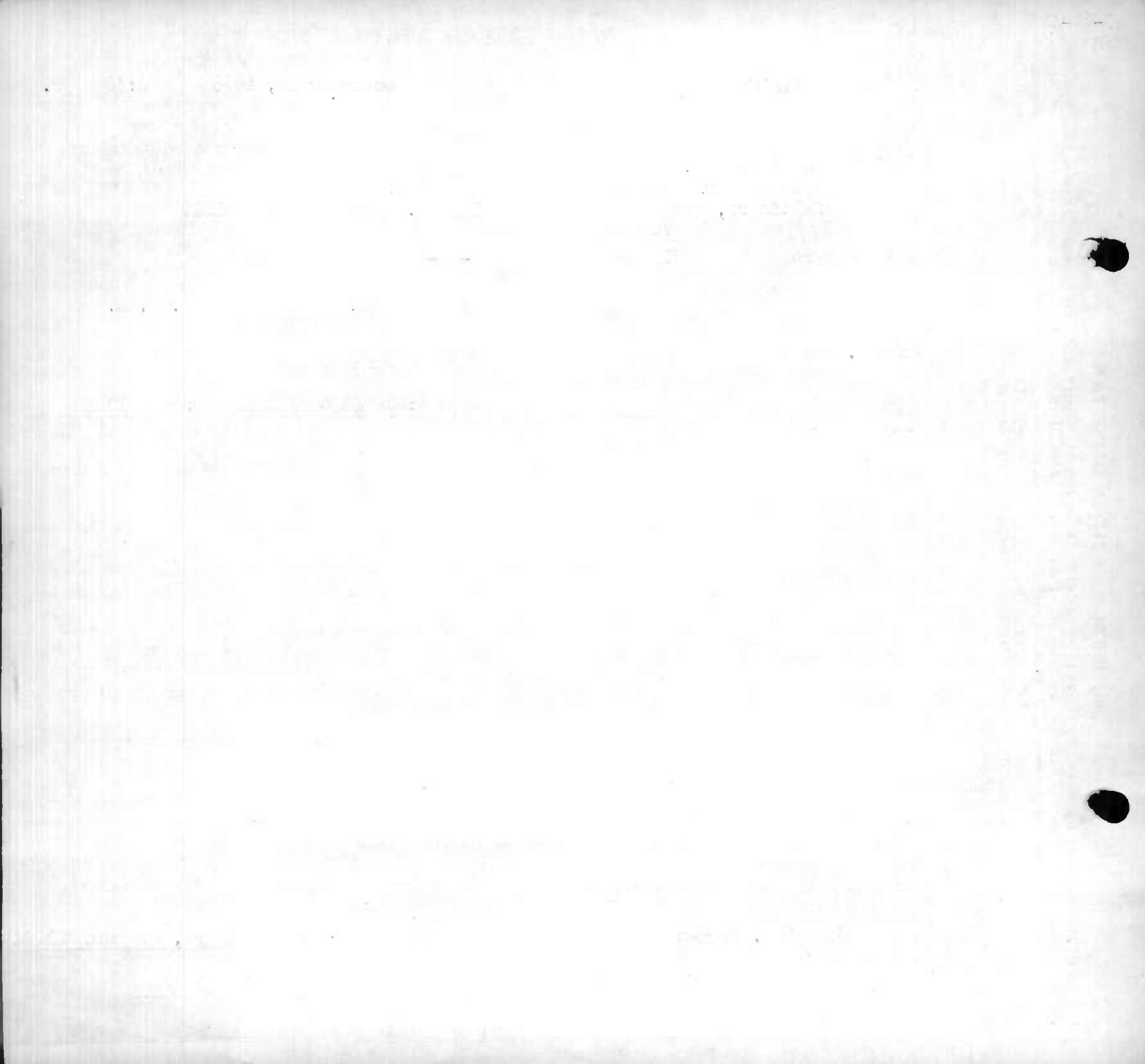
BIRTH NO. 66 12391				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12391	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FAUBER, Phyllis				2. DATE AND HOUR OF DEATH 12/10/66 11:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balto. Co			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital Baltimore Md				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00			
D. STREET ADDRESS (If rural, give location) 2128 Southern Rd.							
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 12/18/16	9. AGE (In years last birthday) 50	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Faubus, Woodrow				14. MOTHER'S MAIDEN NAME Phyllis de Mena			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Gertrude de Mena	
				2128 Southern Rd.		5506 Daywalk Ave.	
18. 560.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Cerebral aneurysm		INTERVAL BETWEEN ONSET AND DEATH 1 3/4 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 10/19		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral aneurysm		20A. AUTOPSY (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/19 1966 to 12/10 1966, that (I) (we) last saw the deceased alive on 12/10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE F. Harley				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/10/66	
23C. PHYSICIAN'S NAME (Type) FRANCS HARLEY				23D. ADDRESS M.D. Sinai Hospital Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-12-66		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.		1217 St. Paul St. Baltimore, Maryland	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12392	
BIRTH NO. 425 66 12392				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Della Wilkins				December 10, 1966   4:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1938 W. MOSHER STREET 21217	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12-12-1902	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John T. Scott			14. MOTHER'S MAIDEN NAME Susan Dempsey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis years					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Emphysema years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (the) (this hospital) attended the deceased from May 24 1965 to 10 Dec 1966, that (we) lost saw the deceased alive on 10 Dec 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph I. Berman M.D.				23B. DATE SIGNED 10 Dec 66	
23C. PHYSICIAN'S NAME (Type) Joseph I. Berman M.D.				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Ceme. A.A.C. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966 Robert E. Sweeney, M.D.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Martone Dyer F.H. 1701 Laurens St.	



1. NAME OF DECEASED (Type or Print) <b>DERRIA FORREST</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>December 10, 1966 6:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>16-04</b> D. STREET ADDRESS (If rural, give location) <b>1112 McKean Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>11-9-1966</b>
9. AGE (In years last birthday) <b>1</b>		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. <b>1 1</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Forrest</b>		14. MOTHER'S MAIDEN NAME <b>Brenda Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs Brenda Thompson</b>		ADDRESS <b>1112 McKean St.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>525X Interstitial Pneumonitis (SDII)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/10/66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>12-13-66</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cem.</b>		23D. LOCATION (City, town, or county) (State) <b>A.A.Co. Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
24C. FUNERAL DIRECTOR <b>Marlene Dyett F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

SECRET UNIT

WALLLEY FORD

WALLLEY FORD

WALLLEY FORD

66 12394

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12394

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HUGH WHITNEY

2. DATE AND HOUR PRONOUNCED DEAD

12-6-66

12:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

311 S. SHARP STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

311 S. Sharp Street 21201

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9-20-1922

9. AGE (in years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Osceola, Ark.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Boyd

14. MOTHER'S MAIDEN NAME

Mamie Mann

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW 11

16. SOCIAL  
SECURITY NO.

372-20-7275

17. INFORMANT

ADDRESS

Mrs. Louella B. Baker 10 Oliver Ave  
White Plains, N.Y.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-15-66

23C. NAME of CEMETERY or CREMATORY

Long Island National

23D. LOCATION

(City, town, or county)

(State)

Farmingdale, N. Y.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 12 1966 Robert E. Taylor, M.D.

Morton &amp; Dyett F. H. 1701 Laurens St.

ALLIEN TOP SECRET

SECRET

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 12395		REGISTERED NO. 66 12395	
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>MARY LORETTA Wess</i>				<b>2. DATE AND HOUR OF DEATH</b> <i>12.10.66</i> <i>1 A.M.</i>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Little Srs. of the Poor</i> <i>1200 VALLEY ST,</i> <i>BALTIMORE MD 21202</i>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY _____  <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>  <b>D. STREET ADDRESS</b> (If rural, give location) <i>1200 VALLEY ST.</i>			
<b>5. SEX</b> <i>F</i>	<b>6. RACE</b> <i>W</i>	<b>7. MARRIED, NEVER MARRIED</b> (WIDOWED, DIVORCED (specify)) <i>WIDOWED</i>	<b>8. DATE OF BIRTH</b> <i>July 19, 1878</i>	<b>9. AGE</b> (In years last birthday) <i>88</i>	<b>If Under 1 Yr.</b> Months: _____ Days: _____	<b>If Under 24 Hrs.</b> Hours: _____ Min. _____	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (State or foreign country) <i>BALTIMORE</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>John B. Tolley</i>			<b>14. MOTHER'S MAIDEN NAME</b> <i>MARY E. LAMBDIN</i>				
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		<b>16. SOCIAL SECURITY NO.</b> <i>213-542376</i>		<b>17. INFORMANT</b> ADDRESS <i>Little Sisters of The Poor</i>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>CAUSE OF DEATH</b> (A) DUE TO <i>C.V.A.</i> (B) DUE TO <i>G.S.C.V.D.</i> (C) <i>Generalized arteriosclerosis</i>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>  	
<b>19A. DATE OF OPERATION</b> <i>0</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  		<b>20A. AUTOPSY?</b> (Yes or No) _____		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>  	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) _____			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) _____		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>  			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>1966</i> <b>to</b> <i>12.10.1966</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>12.10.1966</i> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <i>Stanley Ankudas</i> M.D.				<b>23B. DATE SIGNED</b> <i>12.12.66</i>		<b>23C. PHYSICIAN'S NAME</b> (Type) <i>STANLEY Ankudas</i> M.D.	
<b>23D. ADDRESS</b> <i>401 Maiden Choice Lane MD.</i>				<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>			
<b>24B. DATE</b> <i>12/13/66</i>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <i>Cathedral</i>		<b>24D. LOCATION</b> (City, town, or county) (State) <i>Baltimore</i>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>DEC 12 1966</i>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Taylor</i>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <i>2024</i> <i>Philip Herwig Sons Orleans St</i>			

1893  
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12396		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12396	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Hockenberry Albert		2. DATE AND HOUR OF DEATH Dec 12-66 3 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 49 NORTH CHARLES HOSPITAL		A. STATE BALTO B. COUNTY MD.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-12			
		D. STREET ADDRESS (If rural, give location) 3738 Overview Road			
5. SEX Fe	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 2-14-02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10B. KIND OF BUSINESS OR INDUSTRY CARR. LOWERY- CO.		11. BIRTHPLACE (State or foreign country) OHIO	12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME Samuel B. Phillips		14. MOTHER'S MAIDEN NAME Burns		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
		16. SOCIAL SECURITY NO. 279-12-4722		17. INFORMANT sister	
				ADDRESS 3738 Overview Rd	
18. 151X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Ca stomach (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 mts			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Stella M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Dec 12-66	
23C. PHYSICIAN'S NAME (Type) C. STELLA		23D. ADDRESS N. CHARLES HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/66		24C. NAME OF CEMETERY or CREMATORY Lake View Mem Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT DEC 12 1966		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Philip Henry [unclear] 2024 [unclear]	

North Charles Hospital  
2-14-65  
W

PACKER CAR LOWERY CO.  
B. Phillips  
Bates

219-5-0325  
Dexter  
Ca. Stomach

C. Stella  
M.D.  
A. STELLA

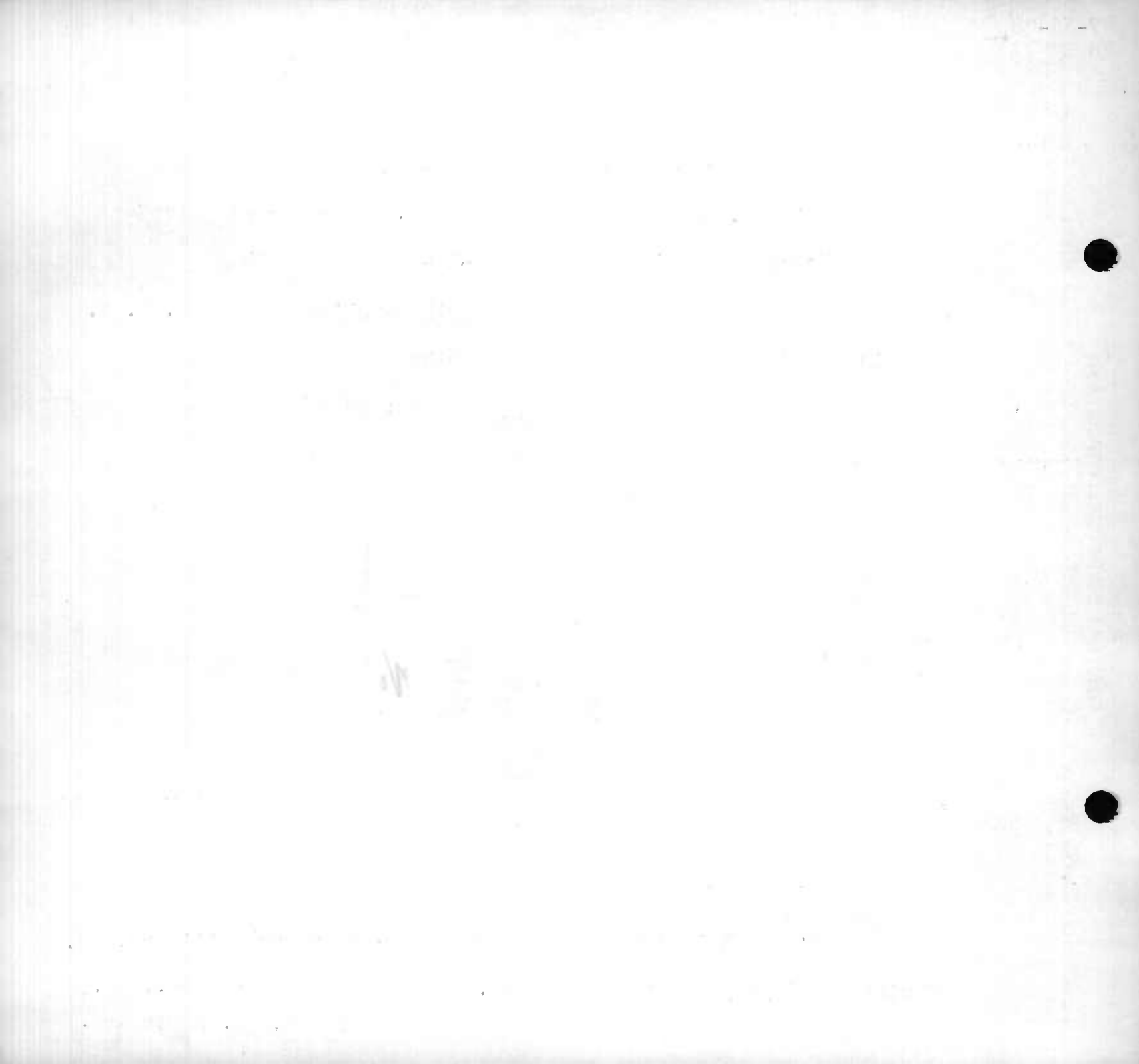
N. CHARLES HOSPITAL  
X  
Dec 25

47-56-28  
FR

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12397	
BIRTH NO. 65266 12397				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Barnes, Naomi</i>		2. DATE AND HOUR OF DEATH 12-9-66 8:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 1809 E. Eager Street 21205		5. SEX Female		6. RACE Negro	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 3-16-1892		9. AGE (In years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Martin		14. MOTHER'S MAIDEN NAME Martha	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Generalized ASCVD DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 12-6 to 12-9-66, that (I) ( <del>we</del> ) last saw the deceased alive on 12-6-66 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.	
23A. SIGNATURE <i>David J. Mishelovich</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-9-66	
23C. PHYSICIAN'S NAME (Type) David Mishelovich		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 12/13/66		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cem.		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Wm C. March		25C. FUNERAL DIRECTOR ADDRESS 928 E. North Ave.	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 12398				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12398	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>James D. Bond</b>				2. DATE AND HOUR OF DEATH <b>Dec. 11, 1966</b>   <b>9 30</b> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>113 W. 22nd Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>12-07</b> D. STREET ADDRESS (If rural, give location) <b>113 W. 22nd Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>Jan. 1, 1894</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>010-03-7019</b>		17. INFORMANT <b>Daisy Howard</b> ADDRESS <b>113 W. 22nd Street</b>		
18. <b>442X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cardiovascular-Renal Disease</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 4, 1966</b> to <b>Dec. 11, 1966</b> and that (I) (we) lost saw the deceased alive on <b>Dec. 4, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>William R. Johnson</i>				23B. DATE SIGNED <b>12-12-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>William R. Johnson</b>				23D. ADDRESS M.D. <b>403 Medical Arts Bldg. Baltimore Md. 212</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/14/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Cty., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Wm C March</b>		25C. FUNERAL DIRECTOR ADDRESS <b>928 E. North Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12339				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12339	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Giovanni Cefalu.</u>				2. DATE AND HOUR OF DEATH <u>12/10/66</u> <u>5:30 P.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland.</u>		B. COUNTY	
<u>3730 Gibbons Ave.</u>		<u>00</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore.</u>		D. STREET ADDRESS (If rural, give location) <u>3730 Gibbons Ave.</u>	
5. SEX <u>Male.</u>	6. RACE <u>White.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widower.</u>	8. DATE OF BIRTH <u>1/1/1884</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed.</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Fruit &amp; Produce Bus.</u>		11. BIRTHPLACE (State or foreign country) <u>Cefalu Italy.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Vincent Cefalu.</u>			
14. MOTHER'S MAIDEN NAME <u>Rosalia Glorioso.</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>			
16. SOCIAL SECURITY NO. <u>219324279</u>				17. INFORMANT <u>Samuel V. Cefalu.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>163X + 260X</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <u>Carcinoma of lung.</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>6 month</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetic mellitus.</u>				<u>chronic Bronchitis.</u>		<u>3 years.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>September</u> 19 <u>66</u> to <u>Nov 21</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 21</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Samuel Whitehouse</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/12/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Samuel Whitehouse.</u>				23D. ADDRESS M.D. <u>3900 N. Charles St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial.</u>		24B. DATE <u>12/14/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>		25B. NAME OF REGISTRAR <u>Leonard J. Ruck, inc.</u>		25C. FUNERAL DIRECTOR <u>5305 Hargford Rd.</u>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 12400					CERTIFICATE OF DEATH			Registered No. 66 12400											
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <i>Wellslager, Maurice M.</i>					2. DATE AND HOUR OF DEATH <i>12/11/1966 3:25 A.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland General Hospital</i>					(If not in hospital or institution, give street address or location)					A. STATE <i>Md.</i> B. COUNTY <i>Baeto</i>									
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baeto 26-01</i>									
										D. STREET ADDRESS (If rural, give location) <i>4912 Franford Ave</i>									
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i>		8. DATE OF BIRTH <i>11/02/20</i>		9. AGE (In years last birthday) <i>46</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Planning Clerk</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Martin-Marietta</i>					11. BIRTHPLACE (State or foreign country) <i>Md.</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>George E Wellslager</i>					14. MOTHER'S MAIDEN NAME <i>Winifred (Kirkham) Kirkham</i>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW 2</i>					16. SOCIAL SECURITY NO. <i>214189943</i>					17. INFORMANT <i>Charl</i>					ADDRESS				
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										(A) <i>Septic shock</i>									
ANTECEDENT CAUSES										(B) <i>Refracted Intestinal Obstruction</i>									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C) <i>Hysterectomy, hysterectomy for uterine cancer</i>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										<i>Aspiration pneumonia</i>									
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <i>12/9/66</i> 19 <i>66</i> to <i>12/11</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/11</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>Daniel C. Wilkerson</i>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>12/11/66</i>				
23C. PHYSICIAN'S NAME (Type) <i>Daniel C. Wilkerson</i>										M.D. 23D. ADDRESS <i>421 Regester Ave</i>									
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>					24B. DATE <i>12-14-66</i>					24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>					24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 13 1966</i>					25B. NAME OF REGISTRAR <i>D. J. Ruck</i>					25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>					ADDRESS <i>Baltimore, Md.</i>				

1000 11/20/00

2000 11/20/00

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

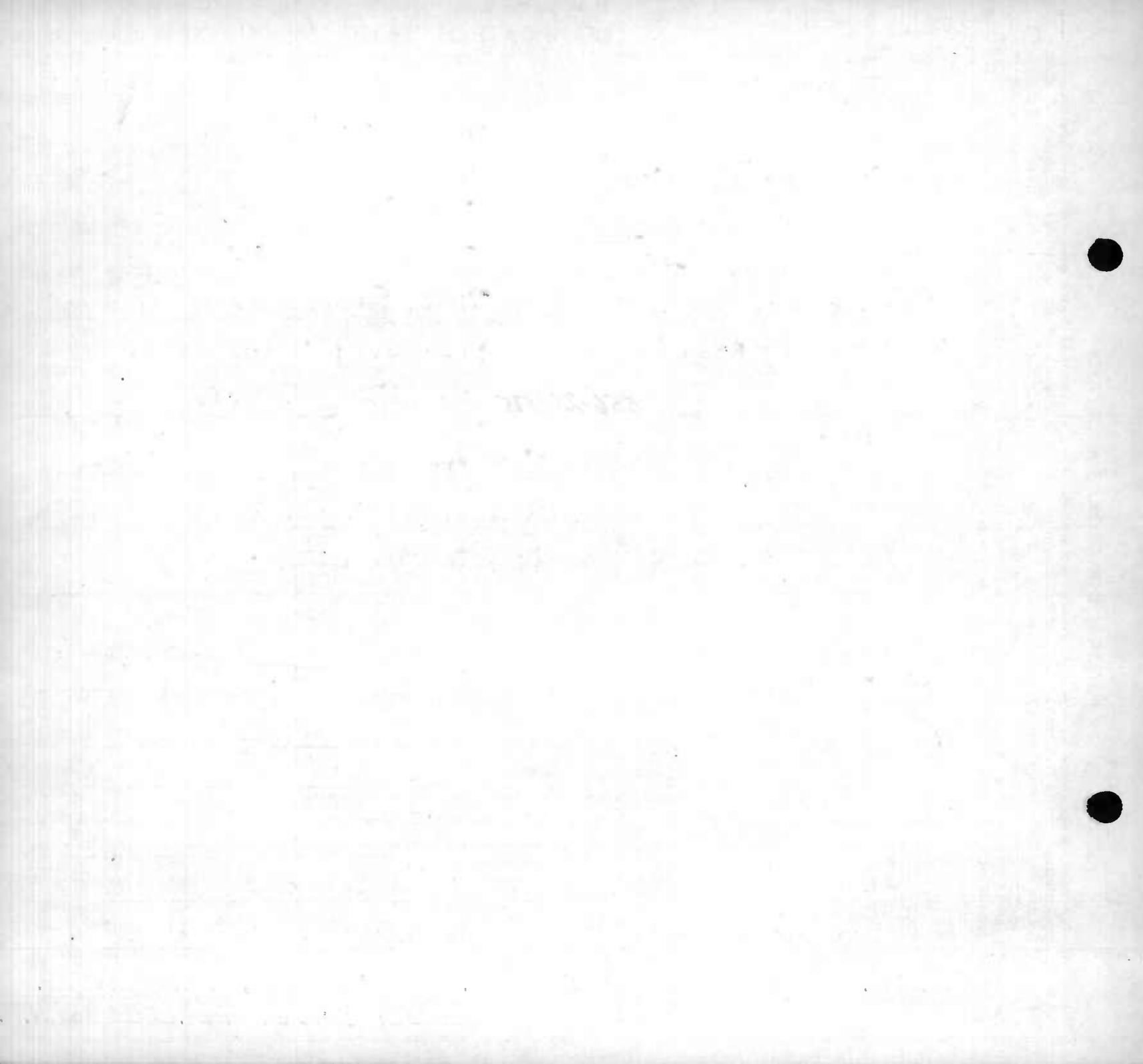
Baltimore City Health Department				Registered No. 66 12401	
BIRTH NO. 66 12401		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MILDRED MARIE BUSH</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 10, 1966 6:10 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>1618 HARTSDALE RD</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>8-25-02</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>CHARLES HARTMAN</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE O'BRYAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218102612</u>		17. INFORMANT <u>MRS SHIRLEY KLOID</u>	
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the immediate cause of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CONGESTIVE HEART FAILURE</u> DUE TO (B) <u>ASCVD</u> DUE TO (C) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u> <u>?</u> <u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>GANGRENE LEFT FOOT, post amputation 7 days</u>					
19A. DATE OF OPERATION <u>12-6-1966</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GANGRENE LEFT FOOT</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>DECEMBER 3, 1966</u> to <u>DECEMBER 10, 1966</u> , that (I) ( <u>we</u> ) lost saw the deceased alive on <u>DECEMBER 10, 1966</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) (did not) view the body after death.					
23A. SIGNATURE <u>James H. Carter Jr.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/10/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>James H. Carter Jr.</u>		23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>12-13-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Sullivan</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>			
25D. ADDRESS					

18-220

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

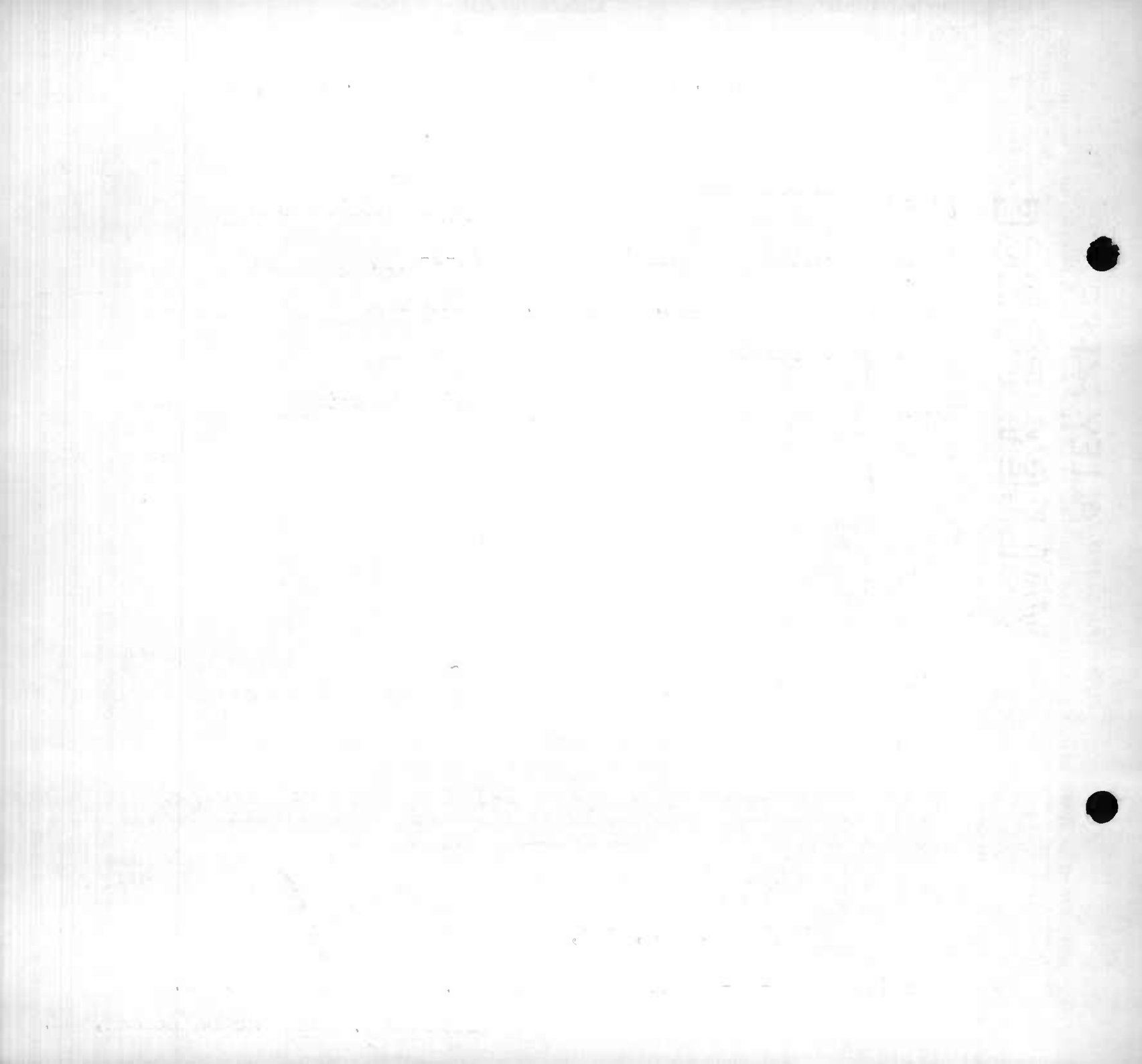
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 12402	
1. NAME OF DECEASED (Type or Print) <b>THREEWITTS, Jos. William</b>				2. DATE AND HOUR OF DEATH <b>December 10<sup>th</sup>, 66   3.50 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Montebello State Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MD, Maryland</b>		B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				D. STREET ADDRESS (If rural, give location) <b>330 St Paul St.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, DIVORCED (specify) <b>single</b>		8. DATE OF BIRTH <b>3/14/1899</b>		9. AGE (In years last birthday) <b>67</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook &amp; Baker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William THREEWITTS</b>				14. MOTHER'S MAIDEN NAME <b>Margaret THORNTON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>556-28-1875</b>		17. INFORMANT <b>Hospital Records</b>		ADDRESS	
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>C.V.A.</b> (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>1962</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized Arteriosclerosis</b> (B) DUE TO <b>Diabetes mellitus</b> (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8-15<sup>th</sup></b> 19 <b>62</b> to <b>Dec 10<sup>th</sup></b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 10</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J.D. Bohorquez MD</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Dec -10 -66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J.D. BOHORQUEZ MD</b>				23D. ADDRESS <b>Montebello State Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial.</b>		24B. DATE <b>12/13/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Sunset Hill Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Littleton, North Carolina.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>J.D. Bohorquez</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Blaylock Funeral Home, Littleton, N.C.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12403</u>	
BIRTH NO. <u>66 12403</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Santo D. Pistorio</u>		2. DATE AND HOUR OF DEATH <u>Dec. 11, 1966</u> <u>6<sup>30</sup> P M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>005430 Sarrill Road</u>		A. STATE <u>Md.</u> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>5430 Sarrill Road</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>12-8-1934</u>	9. AGE (In years lost birthday) <u>32</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joseph Pistorio</u>			14. MOTHER'S MAIDEN NAME <u>Angelo</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>213320169</u>		17. INFORMANT <u>Lois Pistorio</u>	
				ADDRESS <u>same</u>	
18. <u>180 X I</u>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) <u>Carcinoma, left kidney</u> DUE TO <u>with metastases</u>			<u>21 Mon Ths</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ DUE TO			
		(C) _____ DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>23 Jan</u> 19 <u>65</u> to <u>14 Dec</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3 Mar</u> 19 <u>66</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Dr. F. Cox 3d</u>				23B. DATE SIGNED <u>12 Dec 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>William F. Cox, III,</u>				23D. ADDRESS <u>1118 St. Paul St. Baltimore Md 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>12-15-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Baltimore, Md.</u>	

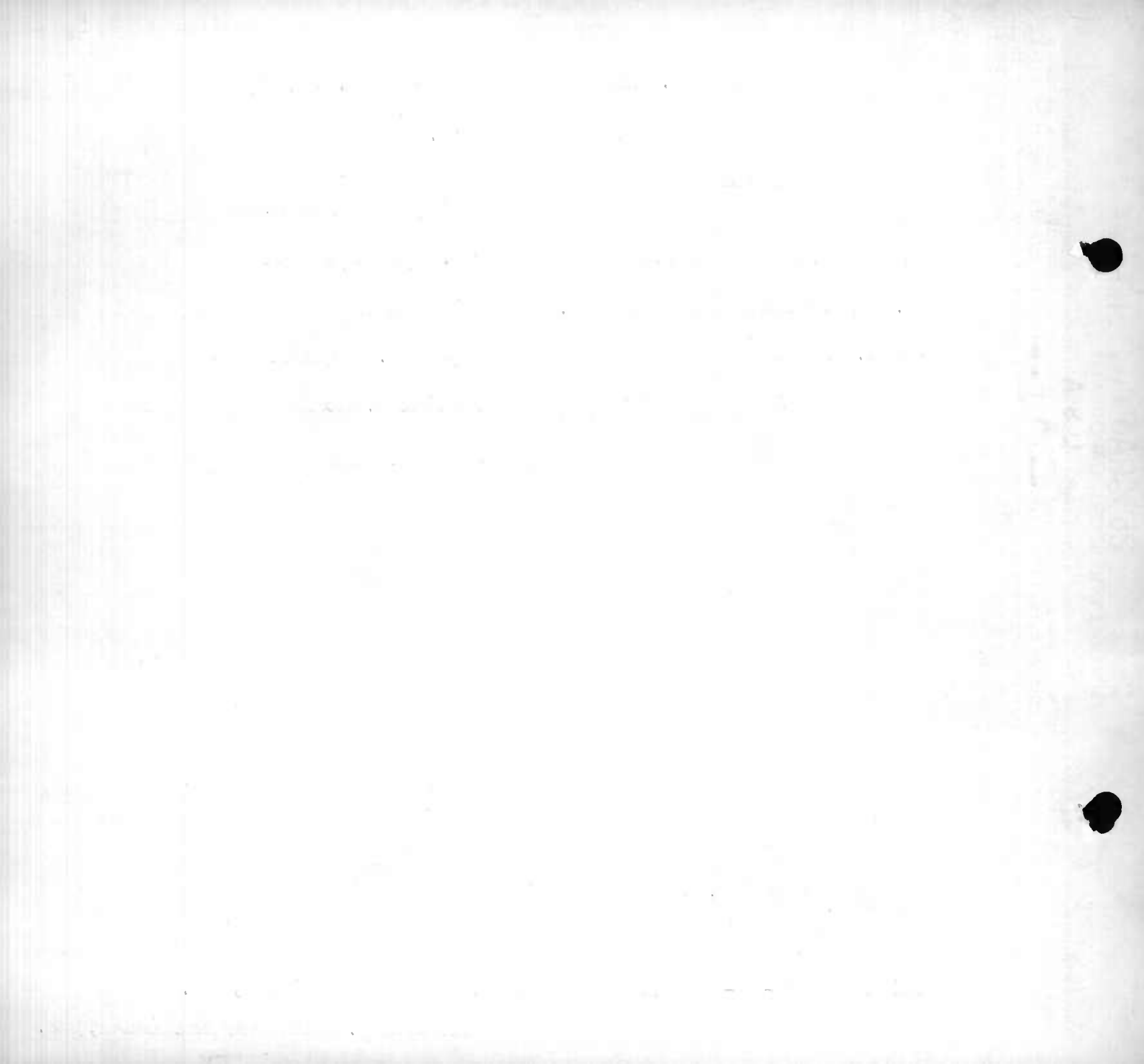




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 68 12404				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68 12404	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				George C. Horst		Dec. 11, 1966 11 30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
6224 Catalpha Road				Md.			
00				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore		27-06	
D. STREET ADDRESS (If rural, give location)				6224 Catalpha Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
male	white	married	Aug. 25, 1898	68			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Ret. Supervisor			Koppers Co.		Maryland		
12. CITIZEN OF WHAT COUNTRY?			USA				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John H. Horst				Cora M. McCandless			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		
yes WW 1			212072431A		Lillian M. Horst		
18. 197.9 I			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) Fibrosarcoma			6 months	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(B) DUE TO				
ANTECEDENT CAUSES			(C) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 7 1966 to Dec 8 1966, that (I) (we) last saw the deceased alive on Dec 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Roy M. Zimmerman						12/12/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Roy M. Zimmerman				M.D. 3202 Hartford Rd, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		12-14-66		Parkwood Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 12 1966		R. G. E. Z. E. E. 2		Leonard J. Ruck Inc		Baltimore, Md.	

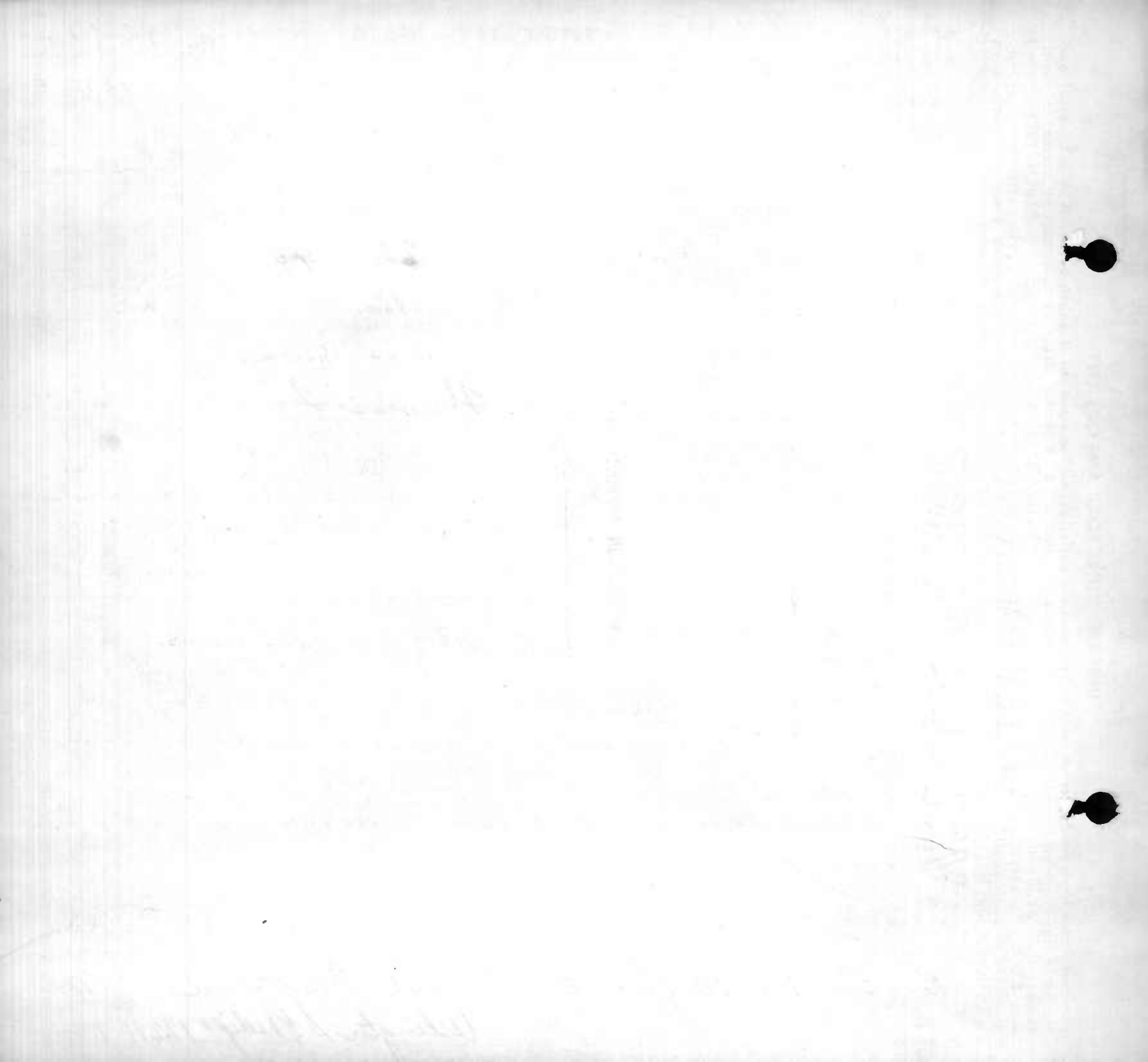


For approval by Medical Examiner

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

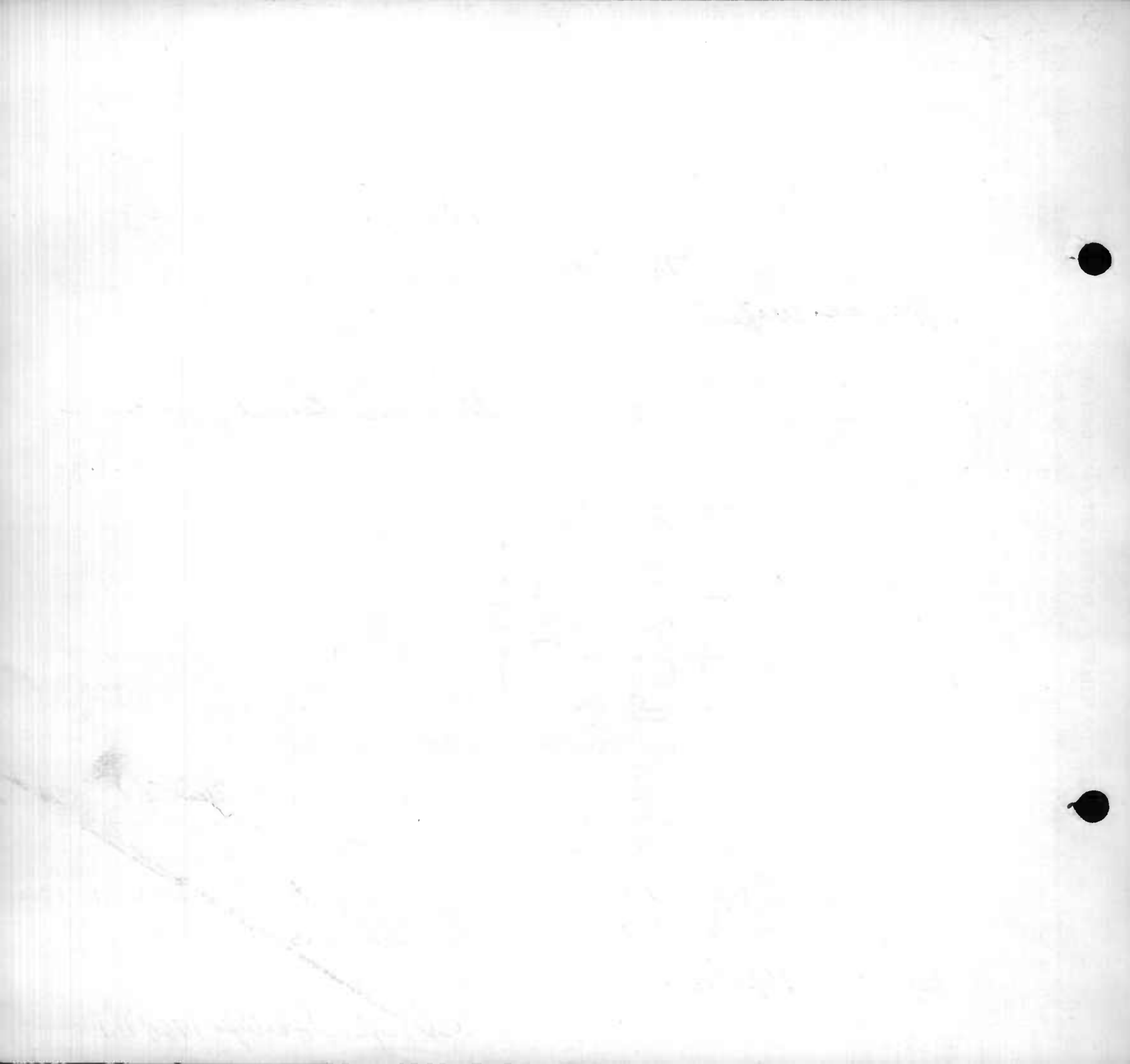
BIRTH NO. 66 12405				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 88-36461	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ERMA TIMMONS, EDNA LOIS</b>				2. DATE AND HOUR OF DEATH <b>12-8-66 12:35 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21216</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 UNIVERSITY HOSPITAL REDWOOD &amp; GREEN STS BALTIMORE, MARYLAND 21201</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 1506</b>			
				D. STREET ADDRESS (If rural, give location) <b>2908 WALBROOK AVE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10/14/22</b>	9. AGE (In years lost birthday) <b>44</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ALABAMA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>MAJOR TERRY</b>			14. MOTHER'S MAIDEN NAME <b>ANNA GARTMON</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>265-8-5002</b>		17. INFORMANT ADDRESS <b>Thomas Timmons Paul</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>421.1 I</b>		CAUSE OF DEATH <b>Left ventricular heart failure 2 hrs. during operation for aortic valve disease</b>		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Aortic valve insuff</b>		20A. AUTOPSY? (Yes or No)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Small aortic aneurysm</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>12-8-66</b>		21E. HOW DID INJURY OCCUR?			
21F. HOW DID INJURY OCCUR?		21G. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from <b>12-4-66</b> 19 to <b>12-8-66</b> 19, that (I) (we) last saw the deceased alive on <b>12-8-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>L. F. A. Adler</b> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>L. F. A. Adler</b> M.D.		23D. ADDRESS <b>University Hospital Balto.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/13/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem Ph. Baltimore Md.</b>		24D. LOCATION (City, town, or county) (State) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Orlington Phillips 1727 N. Monast.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 12406					CERTIFICATE OF DEATH					Registered No. 66 12406				
1. NAME OF DECEASED (Type or Print) <i>Alice Bundy</i>					2. DATE AND HOUR OF DEATH <i>12/4 7:25 AM 66</i>					M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital Baltimore Md.</i>					A. STATE <i>108 S. Fulton Ave</i>					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore Md</i>					1904				
					D. STREET ADDRESS (If rural, give location) <i>108 S. Fulton Ave.</i>									
5. SEX <i>female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>4/15/12</i>		9. AGE (In years last birthday) <i>54</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Suffolk Va</i>				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME <i>George Buckner</i>					14. MOTHER'S MAIDEN NAME <i>Elizabeth Green</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Herman Bundy</i>				
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>E. V. A. ?</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>No</i>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 24</i> 19 <i>66</i> to <i>Dec. 4</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec. 4</i> 19 <i>66</i> and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <i>did</i> (did not) view the body after death.														
23A. SIGNATURE <i>Dong SLP Cha</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>Dec. 4. 1966</i>				
23C. PHYSICIAN'S NAME (Type) <i>DONG SLP CHA</i>					M.D. 23D. ADDRESS <i>BON SECOURS HOSPITAL</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>12/12/66</i>					24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>				
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>					25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1966</i>					25B. NAME OF REGISTRAR <i>Robert E. Talbot</i>				
25C. FUNERAL DIRECTOR <i>Ullington Phillips</i>					ADDRESS <i>1729 N. Mount St</i>									



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12407				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 12407	
1. NAME OF DECEASED (Type or Print) <b>Marshall, Theodore</b>				2. DATE AND HOUR OF DEATH <b>12/10/66 1:30 a.m.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2052 E. Hoffman St.</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>marr</b>	8. DATE OF BIRTH <b>10/26/02</b>		9. AGE (In years last birthday) <b>64</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Chamberlain Vc</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Marshall</b>				14. MOTHER'S MAIDEN NAME <b>CLARA MARSHALL White</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>216-09-5299</b>		17. INFORMANT ADDRESS <b>Orrell Marshall Lane</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>181.0 I</b>				CAUSE OF DEATH (A) <b>Pneumonia</b> DUE TO <b>48 hr.</b>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Carcinoma of the bladder</b> DUE TO <b>3 yr.</b>					
				(C) <b>Poss. CVA</b> <b>60 hr.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>12/9/66</b> 19 to <b>12/11/66</b> 19, that (I) (we) last saw the deceased alive on <b>12/11/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>C.H. Brown, III</b>						23B. DATE SIGNED <b>12/11/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>C.H. BROWN MD</b>						23D. ADDRESS M.D. <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-15-66</b>		24C. NAME of CEMETERY or CREMATORY <b>McCarhey Cmt</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>W. J. S. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Clayton W. Brown 1000 Beauty Ave</b>					

1894  
The above is a list of the  
names of the persons who  
have been elected to the  
office of the Board of  
Education for the year  
1894-1895.

Attest  
The Board of Education  
of the City of New York  
this 1st day of June 1894  
in New York City.  
John A. B. Smith, President  
John A. B. Smith, Secretary



66 12408

BALTIMORE CITY HEALTH DEPARTMENT

66 12408

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ESTELLA CROCKETT

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1966 7:02 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

27 S. Eden Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

May 15 - 1906

9. AGE (In years  
lost birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Edwardsville, Ill

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Jackson

14. MOTHER'S MAIDEN NAME

Mary Ball

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Bertha Ferron

ADDRESS

18.

443 X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Hypertensive cardiovascular disease  
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-13-66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary

23D. LOCATION

(City, town, or county)

Brooklyn

(State)

MD

24A. DATE REC'D BY HEALTH DEPT.

DEC 12 1966

24B. NAME OF REGISTRAR

Robert E. Ferron

24C. FUNERAL DIRECTOR

Eloy O. Wilson or Brantley

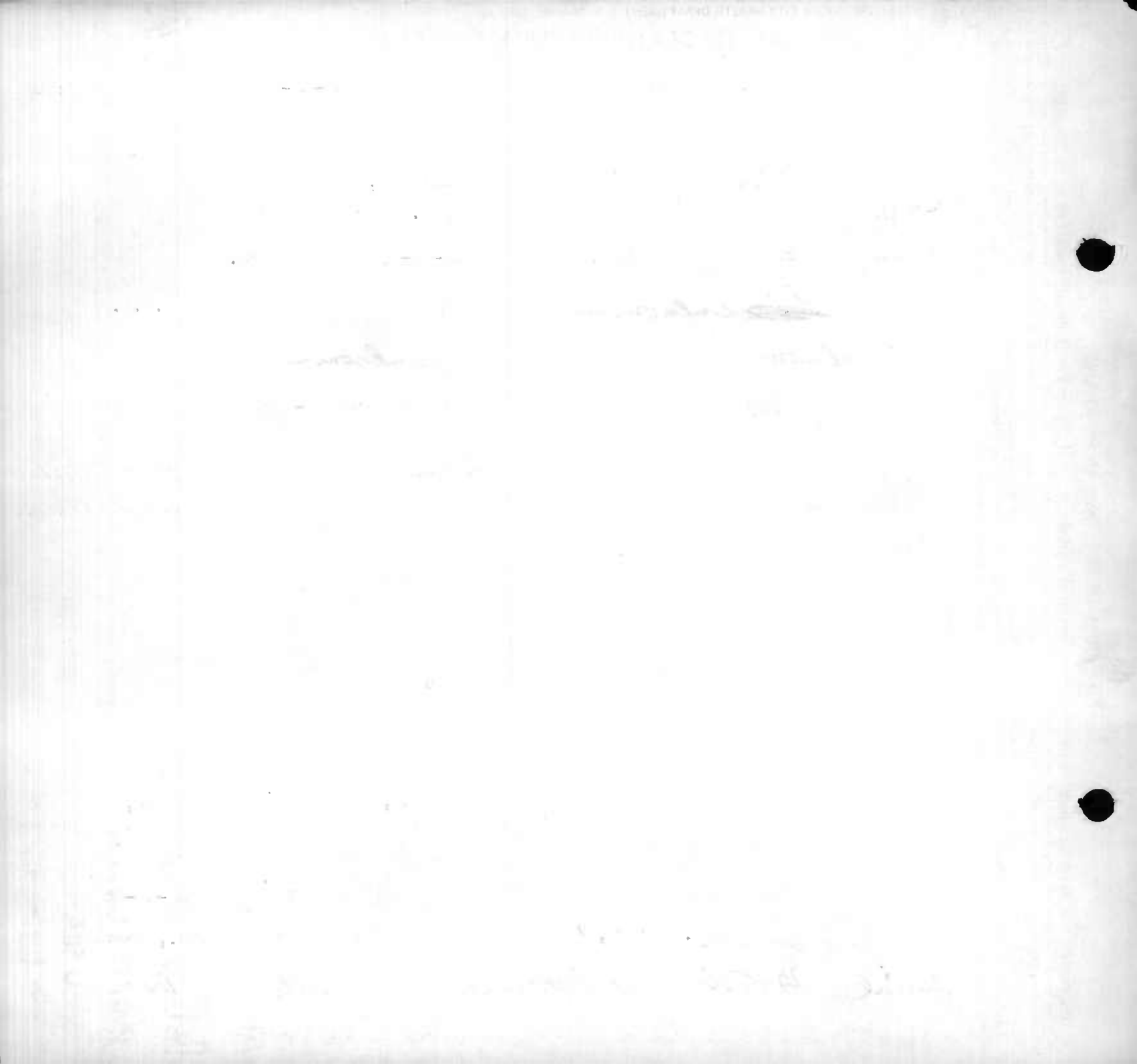
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12409</b>	
BIRTH NO. <b>66 12409</b>				CERTIFICATE OF DEATH	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>Olive Hicks G.</b>		
2. DATE AND HOUR OF DEATH <b>12-10-66</b> <b>4:50A.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital</b> <b>39</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>503 N. Schroeder Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>12-23-03</b>	9. AGE (In years lost birthday) <b>62 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Unknown</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Margaret Brown - friend</b>		ADDRESS <b>SAME</b>
18. <b>334X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Stroke</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Stroke</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>From 12/10/66</b> <b>Tough 12/10/66</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 10, 1966</b> to <b>December 10, 1966</b> , that (I) (we) lost saw the deceased alive on <b>December 10, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <b>Dr. Arnold A. Laredo, M.D.</b>				23B. DATE SIGNED <b>12-10-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Arnold A. Laredo, M.D.</b>				23D. ADDRESS <b>1514 Division Street Balto., Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-15-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Not Antuan Out</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto</b>		24E. LOCATION (City, town, or county) (State) <b>Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Dr. S. J. Wilson</b>		25C. FUNERAL DIRECTOR <b>E. D. Wilson funeral</b>	
25D. ADDRESS <b>1000 Brantley</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12410 5</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>66 12410</u></span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>Johnson, Harry W.</u>			2. DATE AND HOUR OF DEATH <u>12-11-66</u> <u>10.40pm</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>828 E. Eager St.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1-26-14</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Johnson, Harry</u>			14. MOTHER'S MAIDEN NAME <u>Jones, Daisy</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <u>581.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC COMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>? YRS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>RESECTION OF STRANGULATED bowel 1wk</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> <u>1966</u> to <u>12/11</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Mishkin</u>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/11/66</u>
23C. PHYSICIAN'S NAME (Type) <u>S. Mishkin</u>			23D. ADDRESS <u>—</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-15-66</u>	24C. NAME of CEMETERY or CREMATORY <u>MT. Calvary</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn</u> <u>MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1966</u>		25B. NAME OF REGISTRAR <u>—</u>		25C. FUNERAL DIRECTOR ADDRESS <u>—</u>	



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66 12411

BALTIMORE CITY HEALTH DEPARTMENT

66 12411

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>CLAUDE DAVIS</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>December 10, 1966 1:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>33 Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>224 N. Montford Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>8-23-1947</b>	9. AGE (in years last birthday) <b>20 19</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tam Alt</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto Md</b>	
13. FATHER'S NAME <b>Claude Davis Sr</b>		14. MOTHER'S MAIDEN NAME <b>Vernell Hall</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-58-1836</b>		17. INFORMANT ADDRESS <b>Vernell Hall Same</b>	
18. <b>E9824</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hemorrhagic Shock</b> DUE TO <b>Stab Wound of Left Thigh</b> DUE TO (C).....		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Patterson Park Ave. &amp; Orleans St.</b>	
21D. TIME OF INJURY (APPROX.) <b>12 9 '66 11:55p</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Was Stabbed</b>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/10/66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>12-14-66</b>		23C. NAME OF CEMETERY or CREMATORY <b>Balto Natl Cmt</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		24C. FUNERAL DIRECTOR <b>Thos O Wilson 10711 Brantley Rd</b>	

N 890.2

8-23-47 - 12  
Bate Rd  
Lumber Hall  
24-25-26 Lumber Hall - 12

Chick  
Lumber Hall  
24-25-26 Lumber Hall - 12

W. B. Bostwick  
Bate Rd  
Lumber Hall  
24-25-26 Lumber Hall - 12



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 12412	
BIRTH NO.				66 12412	
M.E. CASE NO.				X	
1. NAME OF DECEASED (Type or Print) <b>Bowling, John J. A.</b>			2. DATE AND HOUR OF DEATH <b>12/8/66 12:35 PM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>G.A.C.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Annapolis</b> D. STREET ADDRESS (If rural, give location) <b>52-10 18 Victor Parkway</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3/22/21</b>	9. AGE (In years last birthday) <b>45</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		
11. BIRTHPLACE (State or foreign country) <b>CONFLUENCE Ky.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Irving V. Felix Bowling</b>			14. MOTHER'S MAIDEN NAME <b>Mary Huff</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>			16. SOCIAL SECURITY NO. <b>AHLENE Bowling # 4</b>		
17. INFORMANT ADDRESS <b>AHLENE Bowling # 4</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>581.041 260X</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Upper G.I. hemorrhage</b> (B) <b>CIRRHOSIS → Esophageal Varices</b> (C) <b>Hepatitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>Est. 10 years</b>		
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes, Hypertension</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>1</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 26</b> 19 <b>66</b> to <b>Dec. 8</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec. 8</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>MD Sundel</b>			23B. DATE SIGNED <b>12/8/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>DR. George Zidench</b>			23D. ADDRESS <b>Dept. of Surgery - Johns Hopkins Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-12-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arlington Nat'l.</b>	
24D. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Salome</b>	
25C. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons</b>		25D. ADDRESS <b>Annapolis, Md.</b>			

10/10/52  
10/10/52

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10/10/52

Upper C. ...  
CIRCUIT - ...  
10/10/52

10/10/52  
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10/10/52

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12413		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Hollie Harrison</i>		2. DATE AND HOUR OF DEATH <i>12-9-66 11:15 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hosp. 4940 Eastern Ave. Baltimore, Maryland # 21224</i>		A. STATE <i>Maryland</i> B. COUNTY	
5. SEX <i>Male</i>		6. RACE <i>Negro</i>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>6-23-85</i>	
9. AGE (In years last birthday) <i>81</i>		10. Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Doc Harrison</i>		14. MOTHER'S MAIDEN NAME <i>Henrietta Anderson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>057-09-6145-A</i>		16. SOCIAL SECURITY NO. <i>057-09-6145-A</i>	
17. INFORMANT <i>BCH: Records 4940 Eastern Ave. Baltimore, Md.</i>		ADDRESS <i># 21224</i>	
18. <i>331 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Aspiration Pneumonia</i> DUE TO (B) <i>Massive Pneumonia</i> DUE TO (C) <i>Cerebral Vascular Disease (CVA)</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>7 hrs.</i> <i>2 mos.</i> <i>3 mos.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <i>11-23-66</i> 19 to <i>12-9</i> 19 <i>66</i> , that (we) last saw the deceased alive on <i>12-9</i> 19 <i>66</i> and that (my) (our) applan death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>A T Spear</i>		23B. DATE SIGNED <i>12-9-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>A T Spear</i>		23D. ADDRESS <i>4940 Eastern Ave. Baltimore, Maryland #21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-13-66</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Frances A. Henneley</i>		ADDRESS <i>678 W. Biddle St.</i>	



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66 12414

BALTIMORE CITY HEALTH DEPARTMENT

66 12414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANITA

CARTER

2. DATE AND HOUR PRONOUNCED DEAD

December 11, 1966

9:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

611 Ashburton Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Oct. 3-1927

9. AGE (in years last birthday)

38

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Resturant

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Bernard Queen

14. MOTHER'S MAIDEN NAME

Dorothy Talbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

21722-8561

17. INFORMANT

Alvin Carter 611 Ashburton St.

18.

E976X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Gun Shot Wound of Left Chest  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes - Partial

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

611 Ashburton Street

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 12 11 '66 9:15A

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self

22.

I certify that I held an Inquiry ☐ Inspection ☐ P. Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/11/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12-15-66

23C. NAME of CEMETERY or CREMATORY

Arbutus

23D. LOCATION

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

R. Weinert

ADDRESS

2700 Edmondson Ave

TO THE HONORABLE  
MEMBERS OF THE  
LEGISLATIVE ASSEMBLY  
OF THE PROVINCE OF ONTARIO

IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE ASSEMBLY  
ON THE 14TH DAY OF  
MAY 1907

REPORT OF THE  
COMMISSIONER OF  
THE LAND OFFICE  
ON THE  
LANDS BELONGING TO  
THE PROVINCE OF ONTARIO

PRINTED BY THE  
GOVERNMENT OF ONTARIO  
TORONTO, 1907

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12415	
BIRTH NO. 66 12415		M.E. CASE NO. 66 12415		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY McENTEE		2. DATE AND HOUR OF DEATH 12-9-66 1:00AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD. B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
ST. AGNES HOSPITAL WILKENS & CATON AVES BALTIMORE, 29, MD.		BALTIMORE		BALTIMORE	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	
8. DATE OF BIRTH 10-07-78		9. AGE (In years, months, days) 88		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS		10B. KIND OF BUSINESS OR INDUSTRY RELIGIOUS		11. BIRTHPLACE (State or foreign country) NEW JERSEY PENNA.	
13. FATHER'S NAME UNKNOWN JAMES McENTEE (DEC'D)		14. MOTHER'S MAIDEN NAME UNKNOWN MARY MORAN (DEC'D)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219 54 4445		17. INFORMANT ADDRESS ST. AGNES RECORDS, WILKENS & CATON AVE	
18. 440X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Uremia DUE TO (B) Heart failure DUE TO (C) Hypertension		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 4 19 66 to DECEMBER 9 19 66, that (I) (we) last saw the deceased alive on DECEMBER 9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ESTHER EDERY		23B. DATE SIGNED 12-9-66			
23C. PHYSICIAN'S NAME (Type or Print) ESTHER EDERY		23D. ADDRESS M.D. WILKENS & CATON AVES. BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC 12, 1966		24C. NAME OF CEMETERY OR CREMATORY DOMINICAN SISTERS CONVENT CEMETERY	
24D. LOCATION (City, town, or county) (State) 720 Maiden Choice Lane Catonsville, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 12 1966		25B. NAME OF REGISTRAR J. E. T. T. T.	
25C. FUNERAL DIRECTOR'S ADDRESS 736 Edmondson Av., Catonsville, Md.					

1990

人 口 总 量



1  
K-560

66 12416

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 12416

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EDITH

KAMMER

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1966

10:44 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3628 Keswick Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

1/25/1917

9. AGE (in years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SEAMSTRESS

10B. KIND OF BUSINESS OR INDUSTRY

S &amp; S MANUFACTURING

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

TREVA L. GREENTREE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

115-14-5908

17. INFORMANT

ADDRESS

TREVA L. GREENTREE 3628 KESWICK RD.

18.

443 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic  
Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Obesity

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

12/15/66

23C. NAME of CEMETERY or CREMATORY

DRUID RIDGE

23D. LOCATION

(City, town, or county)

BALTO, MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Paul E. Chouinard  
3617 Chestnut Ave.

ADDRESS

REGISTERED  
242 N. Main St. (N. Main St. N. Main St.)  
NO. 1  
1/2/1917  
THOMAS L. GREEN TRUST  
N. Main St. (N. Main St. N. Main St.)

RECEIVED  
12/12/16  
BANK OF AMERICA  
N. Main St. (N. Main St. N. Main St.)  
N. Main St. (N. Main St. N. Main St.)

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>86 12417</u>
BIRTH NO. <u>66 12417</u>						<b>CERTIFICATE OF DEATH</b>
M.E. CASE NO. _____						
1. NAME OF DECEASED (Type or Print) <u>WILLIAM FRANCIS STERLING</u>				2. DATE AND HOUR OF DEATH <u>10 Dec 66</u> <u>7 30</u> P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> <u>38</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD</u> - B. COUNTY <u>ANNE ARUNDEL</u>		
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>GLEN BURNIE</u> <u>52-00</u>		
				D. STREET ADDRESS (If rural, give location) <u>102 5TH AVENUE S.E.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-25-03</u>	9. AGE (In years lost birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MO.</u>		
13. FATHER'S NAME <u>WILLIAM F. STERLING</u>			14. MOTHER'S MAIDEN NAME <u>MARY E. BUCKLER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT ADDRESS <u>HOSPITAL CHART</u>		
18. <u>161X I</u> CAUSE OF DEATH						
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
(A) <u>CARCINOMA OF THE LARYNX</u>						
(B) DUE TO						
(C) DUE TO						
II						
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <u>11-25-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>TRAUMA TO R eye</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>23 Nov</u> 19 <u>66</u> to <u>10 Dec</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10 Dec 66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Stanley Music</u>				23B. DATE SIGNED <u>10 Dec 66</u>		
23C. PHYSICIAN'S NAME (Type) <u>STANLEY MUSIC</u>				23D. ADDRESS M.D. <u>% UNIVERSITY HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>14 Dec. 66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial</u>		
				24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1966</u>		25B. NAME OF REGISTRAR <u>R. E. F. F.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 12418		CERTIFICATE OF DEATH		Registered No. 7831824	
1. NAME OF DECEASED (Type or Print) <b>DASHER, RANDA C.</b>				2. DATE AND HOUR OF DEATH <b>12-11-66</b> <b>5:40 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>36 Franklin Square Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Howard Co.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Jessup</b> <b>63-00</b>			
D. STREET ADDRESS (If rural, give location) <b>Burger Road</b> <b>Box 168</b>				5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify)) <b>WIDOWED</b>		8. DATE OF BIRTH <b>SEPT 7, 1926</b> 9. AGE (In years (last birthday)) <b>40</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MICHAEL FINK</b>			
14. MOTHER'S MAIDEN NAME <b>MARTHA Cullers</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>214-50-1852</b>		17. INFORMANT ADDRESS <b>Clavis - VIRGINIA STEADMAN NEW MEXICO</b>	
18. <b>175.0 x 260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Terminal stages of cancer</b>				CAUSE OF DEATH (A) DUE TO <b>Ca.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>40</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Malignant Diabetes mellitus</b>		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>12/8/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Radically good</b>		20A. AUTOPSY? (Yes or No) _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Disseminated Carc</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____		21C. WHERE DID INJURY OCCUR? _____					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____					
22. I certify that (I) (this hospital) attended the deceased from <b>Dec, 8</b> 19 <b>66</b> to <b>Dec, 11</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 11</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Chang Kae Kim</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Dec 11, 1966</b>			
23C. PHYSICIAN'S NAME (Type) <b>Chang Kae Kim</b>				M.D. <b>Franklin Square Hospital</b>		23D. ADDRESS _____			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 14, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Johns Lutheran</b>		24D. LOCATION (City, town, or county) (State) <b>Pfeiffers Corner, Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Schell</b>		25C. FUNERAL DIRECTOR <b>F.C. Higinbotham</b>		ADDRESS <b>Ellicott City, Md</b>			

2-1-1952

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12419					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 12419				
1. NAME OF DECEASED (Type or Print) WILLIAMS, EDITH ESTHER					2. DATE AND HOUR OF DEATH 12-10-66 5:20 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. ANNE ARUNDEL Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) PASADENA 52-00 D. STREET ADDRESS (If rural, give location) FT. SMALLWOOD RD.				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-10-99	9. AGE (In years last birthday) 67	10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOREOWNER			10B. KIND OF BUSINESS OR INDUSTRY GROCERY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME MUNRO SMITH					14. MOTHER'S MAIDEN NAME KATHERINE MATTHEISZ				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO. 220-36-6967A		17. INFORMANT ADDRESS KENS AVE. - 21229 BALTO., MD. ST. AGNES HOSP. RECORDS-CATON & WIL-				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 289.2 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <del>Peritonitis</del> (B) <del>Septicemia</del> (C) <del>Electrolyte imbalance</del>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from 11-19-19 66 to 12-10-19 66, that (we) last saw the deceased alive on 12-10-19 66 and that in my opinion death occurred on the date and hour and from the causes stated above, (We) (did) view the body after death.									
23A. SIGNATURE Steve C. Papastephanou					23B. DATE SIGNED 12/10/66				
23C. PHYSICIAN'S NAME (Type) DR. STEVE C. PAPASTEPHANOU					23D. ADDRESS ST. AGNES HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/66		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Pk.		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1966		25B. NAME OF REGISTRAR Robert E. Salome		25C. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.		ADDRESS			

1992

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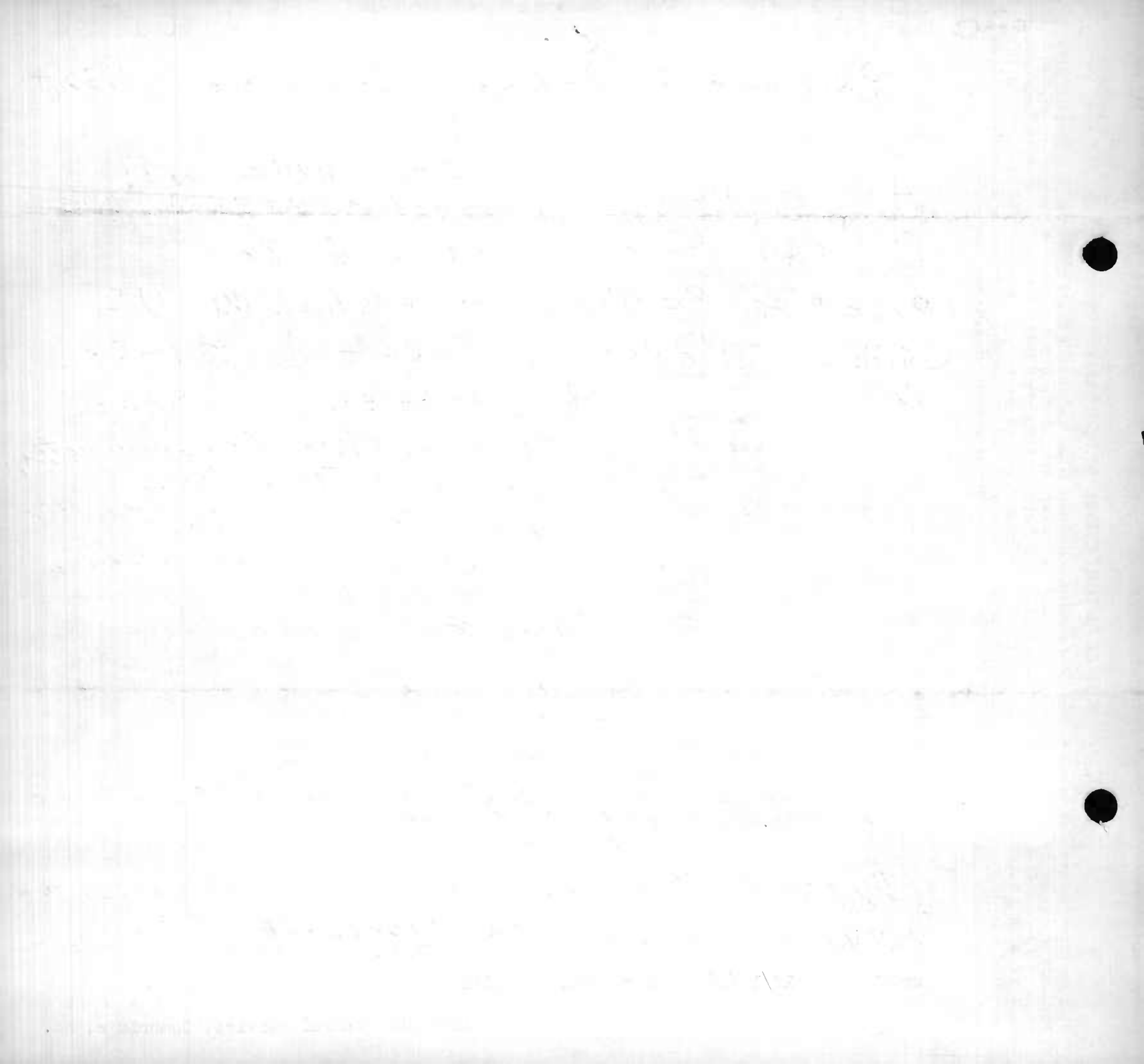
Figure 1



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12420		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12420	
M.E. CASE NO.		1. NAME OF DECEASED PRICILLA F PARKS		2. DATE AND HOUR OF DEATH DEC 10 1966 1:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION DOAT HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2744 D. STREET ADDRESS (If usual, give location) 5917 BERTRAM AVE			
5. SEX F	6. RACE CAU	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH APR 28 1888	9. AGE (In years last birthday) 86	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) HOOPERSVILLE, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JAMES PARKS		14. MOTHER'S MAIDEN NAME SARAH J. RUARK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNK		17. INFORMANT DAUGHTER ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 260X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. statue pneumonia		CAUSE OF DEATH (A) DUE TO Cerebral Thrombosis (B) DUE TO Cerebral arteriosclerosis (C) DUE TO Diabetes mellitus, Brittle Chumney Tract Infection		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Sept 15 1965 to Dec 10 1966, that (I) (we) last saw the deceased alive on Dec 9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Donald W. Mintzer M.D.		23B. DATE SIGNED Dec 10 1966		23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER	
23D. ADDRESS 3009 EVERGREEN AVE. Baltimore Md 21214		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/66	
24C. NAME OF CEMETERY or CREMATORY Dorchester Memorial Park		24D. LOCATION (City, town, or county) Cambridge, Maryland		24E. STATE (State) Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Md.	



66 12421

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12421

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN J. NAGEL

2. DATE AND HOUR PRONOUNCED DEAD

12-12-66

12:40 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL - DOA

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1515 Patapsco Street 21230

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan. 24, 1920

9. AGE (In years  
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Chemist

10B. KIND OF BUSINESS OR INDUSTRY

Bottling Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

John H. Nagel

14. MOTHER'S MAIDEN NAME

Margaret Raftery

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Lawrence Nagel

ADDRESS

124 W. Randall St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPIITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-12-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12 15 1966

23C. NAME of CEMETERY or CREMATORY

Holy Cross

23D. LOCATION

(City, town, or county)

(State)

Brooklyn, A. A. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1966

24B. NAME OF REGISTRAR

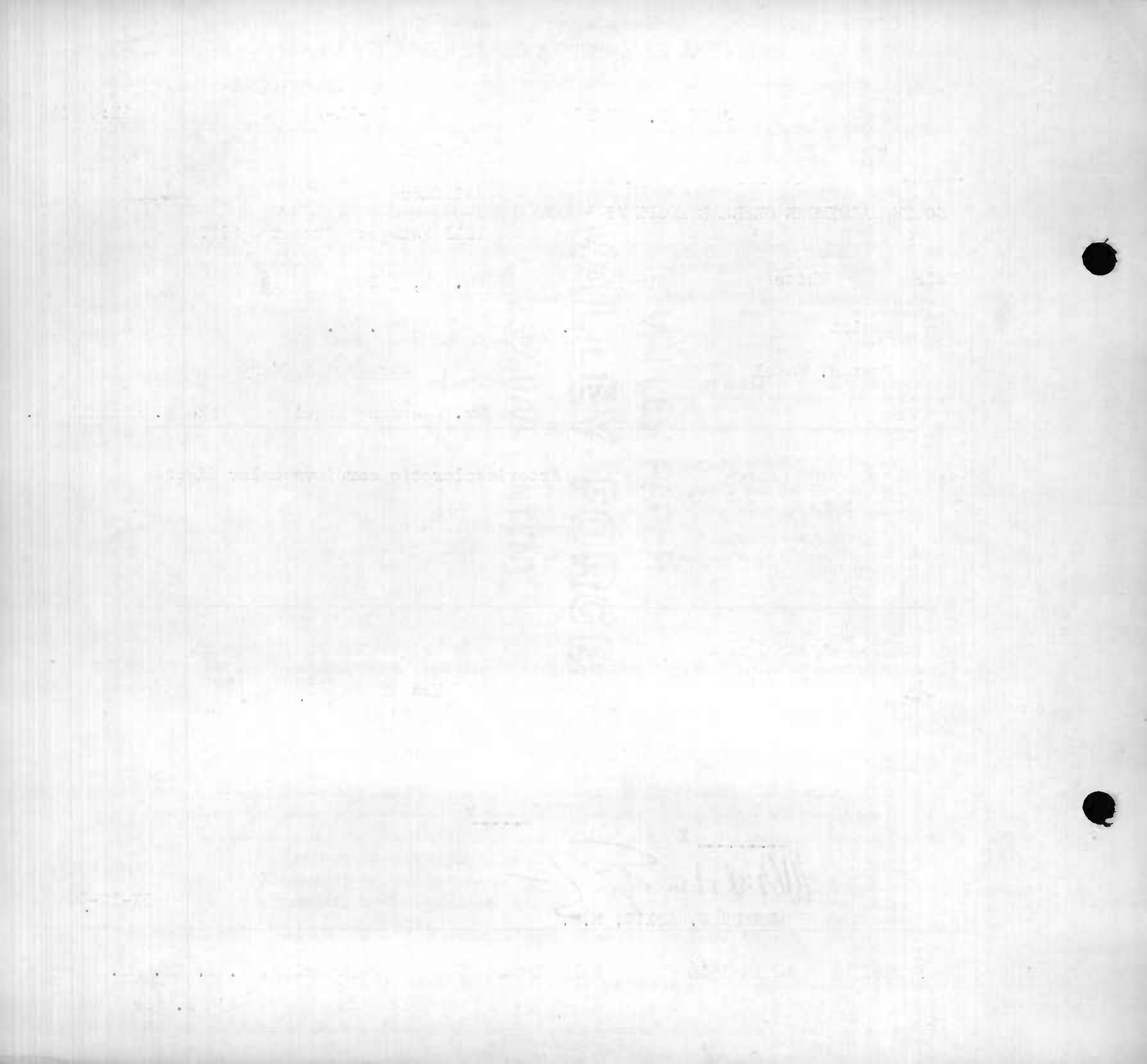
Robert E. Farley

24C. FUNERAL DIRECTOR

Mc Gully

ADDRESS

130 E. Fort Ave



66 12422

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12422

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

THAD

L.

LILLEY SR.

2. DATE AND HOUR PRONOUNCED DEAD

December 11, 1966

12:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

43

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

25-05

D. STREET ADDRESS (If rural, give location)

4120 Curtis Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 13, 1903

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Electric Co.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

George Lilley

14. MOTHER'S MAIDEN NAME

Cora Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Thad Lilley Jr.

ADDRESS

4120 Curtis Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/11/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-11-66

23C. NAME of CEMETERY or CREMATORY

Greenwood Cemetery

23D. LOCATION

(City, town, or county)

(State)

Tarboro, Edgecombe, N.C.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1966

24B. NAME OF REGISTRAR

Robert E. Fasham

24C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

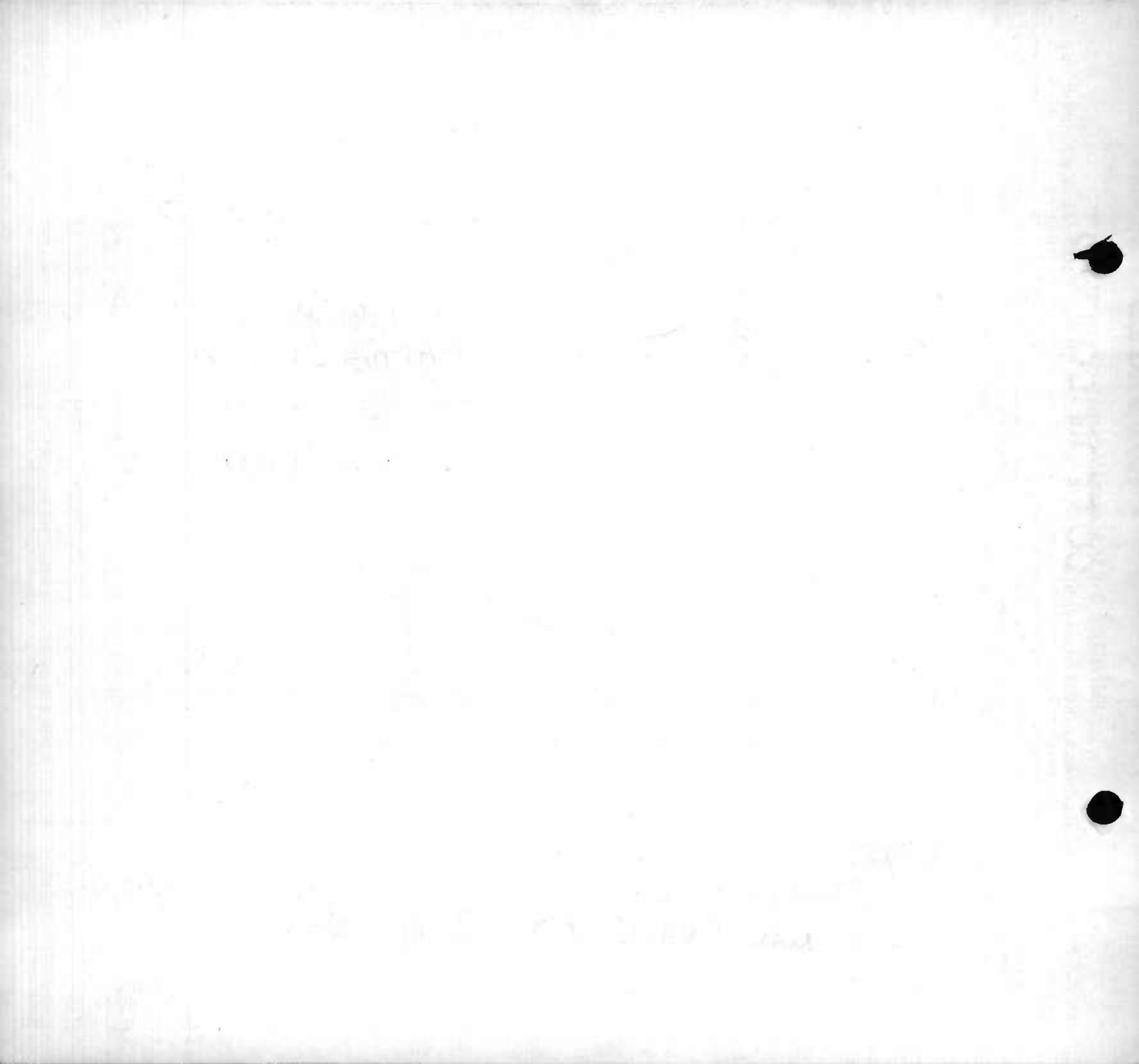
130 E. Fort Ave



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 62-59119-66 12423				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12423	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>PRETTYMAN ROXIE</b>				2. DATE AND HOUR OF DEATH <b>12/10/66 6:30 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 Sinai Hospital Baltimore, Maryland</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>15-01</b> D. STREET ADDRESS (If rural, give location) <b>1500 BAKER ST.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>single</b>	8. DATE OF BIRTH <b>8-3-62</b>	9. AGE (In years lost birthday) <b>4</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL PRETTYMAN</b>				14. MOTHER'S MAIDEN NAME <b>HATTIE LAWRENCE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Hattie Prettyman 1500 Baker Street</b>	
18. <b>180X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>METASTATIC WILMS</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>NOV 1964</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>WILMS TUMOR</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>NOV 1964</b> to <b>PRESENT</b> 19____, that (I) (we) last saw the deceased alive on <b>DEC 5</b> 19 <b>1966</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sherman Su Chang</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/10/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>SHERMAN CHANG M.D.</b>				23D. ADDRESS <b>SINAI HOSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-13-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George Kelson 1348 N. Calhoun Street</b>			

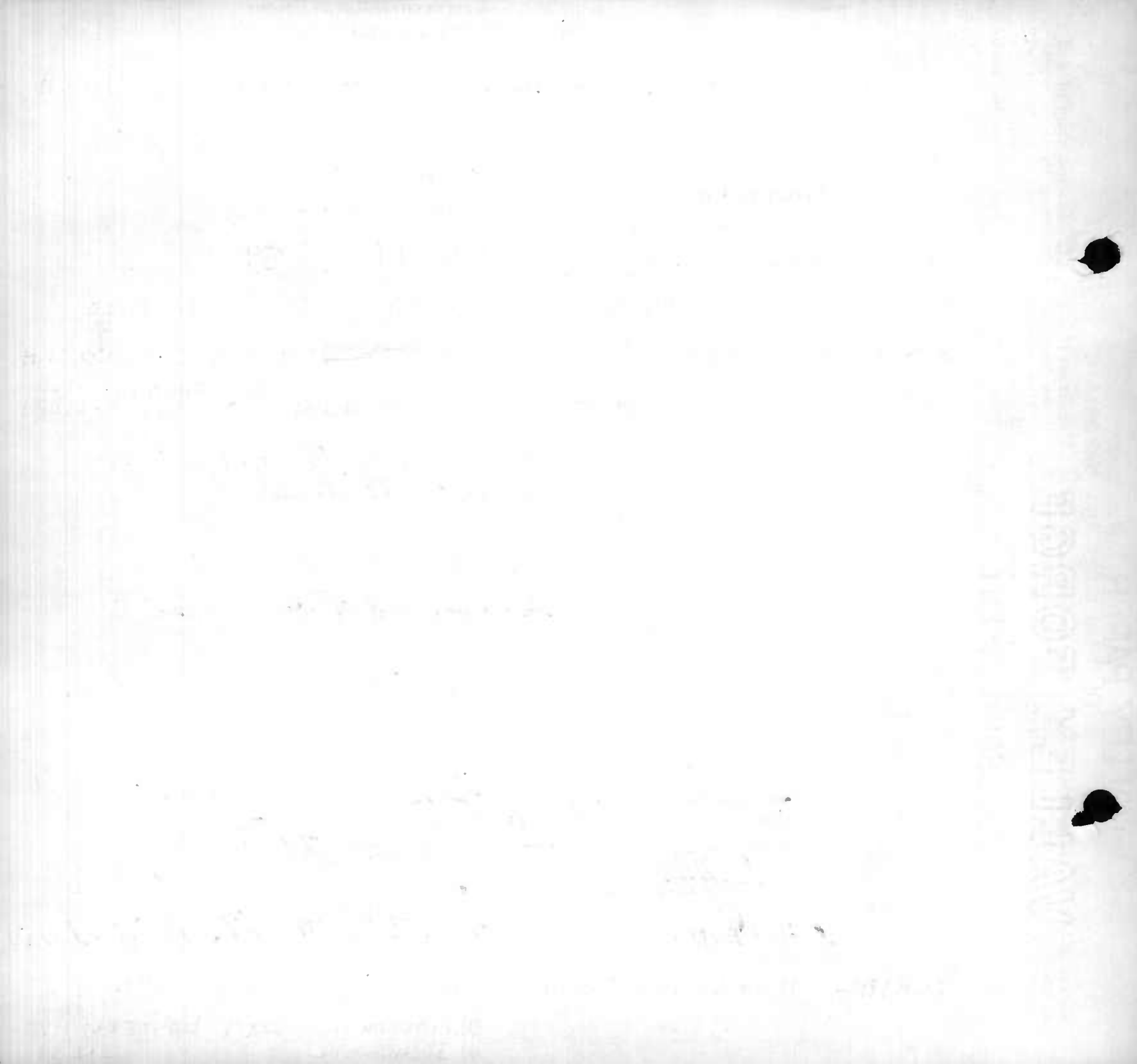




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12424</u>	
BIRTH NO. <u>66 12424</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MIEZEJEWSKI-KOLAKOWSKI, MARYANNA</u>		2. DATE AND HOUR OF DEATH <u>DEC. 11, 1966</u> <u>7:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>21231</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>2-01</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 BALTO. MD. 21231</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>1916 EASTERN AVE.</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>2-2-77</u>	9. AGE (In years lost birthday) <u>89</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>POLAND</u>		13. FATHER'S NAME <u>GEORGE SCZEPKOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>ANGELA CHELHODWSKA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO. -</u>		17. INFORMANT ADDRESS <u>L.M. KOLAKOWSKI 1916 EASTERN AVE. BALTO. MD. 21231</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>151X I</u>		CAUSE OF DEATH (A) DUE TO <u>Carcinoma of Stomach with metastasis</u> (B) DUE TO <u>Generalized arterio-sclerosis</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>Jan 16</u> to <u>Dec 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 10</u> , 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>7 A.M.</u>					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/17/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>I. J. FEINGLOS</u>		M.D. <u>2007 E. Pratt St. Balto. Md 21231</u>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-14-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY ROSARY CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1966</u>		25B. NAME OF REGISTRAR <u>P. J. H. E. FALCOWSKI</u>	
25C. FUNERAL DIRECTOR <u>W. FIALKOWSKI</u>		25D. ADDRESS <u>2007 EASTERN AVE. 21231</u>		25E. ADDRESS <u>21231</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12425	
BIRTH NO. 66 12425		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SISTER MARY GRACE DUFFY		2. DATE AND HOUR OF DEATH 12/10/66- 3:10 P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital		A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		28-41	
		D. STREET ADDRESS (If rural, give location) VILLA ST. MICHAEL			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 2/09/1872	9. AGE (In years last birthday) 94	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IRELAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME CHARLES (DECEASED)		14. MOTHER'S MAIDEN NAME MARY GRANT (DECEASED)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES RECORDS, WILKENS & CATON AVES.	
18. 002.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Massive Hemoptysis DUE TO (B) Old Fibrose Tuberculosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 12/8/66 1966 to 12/10 1966, that (X) (we) last saw the deceased alive on 12/10 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) E. H. Weiss		23D. ADDRESS M.D. ST. AGNES HOSPITAL WILKENS & CATON BALTIMORE, MD., 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/13/66		24C. NAME OF CEMETERY or CREMATORY Seton Cemetery (on grounds of Seton Institute)	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1966		25B. NAME OF REGISTRAR Robert E. Salerna		25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN COMPANY 108 W. North Av. City	

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BIRTH NO. 66 12426		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12426	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Juanita Ruby Martin</i>		2. DATE AND HOUR OF DEATH <i>Dec 11th 66</i> <sup>10</sup> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 So. Balto. Gen. Hosp.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1128 Carroll St.</i>			
5. SEX <i>M.</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12/27-06</i>	9. AGE (In years last birthday) <i>59</i>	10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>Texas</i>	
13. FATHER'S NAME <i>Virgil S. Pittman</i>		14. MOTHER'S MAIDEN NAME <i>Lille B. Jones</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-07-9281</i>		17. INFORMANT <i>Mr. William Jones</i> ADDRESS <i>147 Margaret St. Rd.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Diabetic Acidosis</i>		CAUSE OF DEATH (A) DUE TO <i>Diabetic Acidosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 day</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Gangrene Left big toe</i>		(B) DUE TO <i>Diabetes Mellitus</i>		<i>14 days</i>	
(C) <i>Diabetes Mellitus</i>				<i>3 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/9</i> 19 <i>66</i> to <i>12/11</i> 19 <i>66</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>12/9</i> 19 <i>66</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <i>John P. Urlock Jr</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/12/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN P. URLOCK JR</i>		23D. ADDRESS <i>1227 Washington Blvd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/14/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Olivet Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 13 1966</i>			
25B. NAME OF REGISTRAR <i>John J. Cowan &amp; Son Inc</i>		25C. FUNERAL DIRECTOR <i>Hollins</i>			

Charles H. H. H. H.

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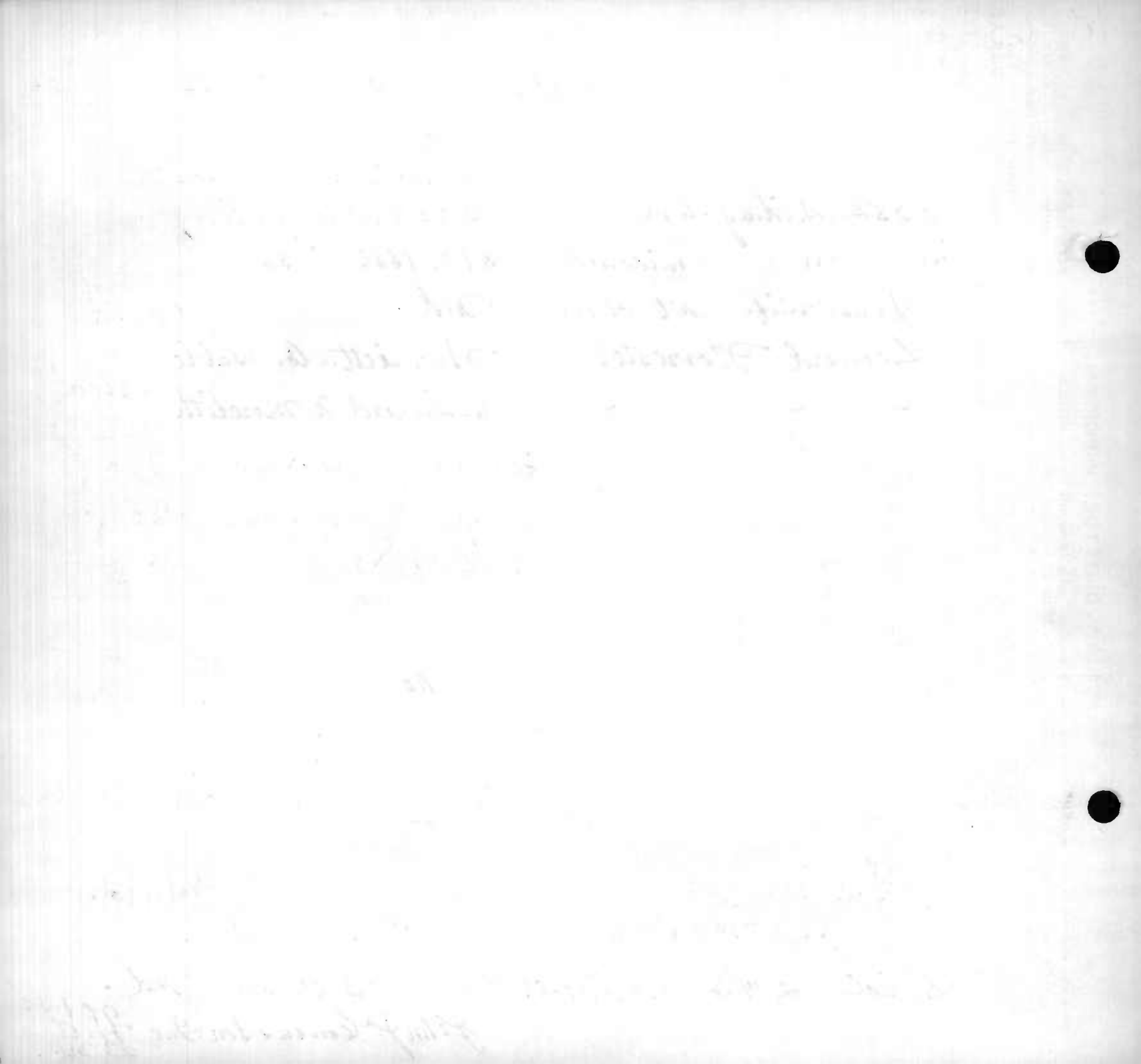
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**FUNERAL DIRECTOR: IMPORTANT**

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BIRTH NO. 66 12427		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12427	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lottie M. Meredith</i>		2. DATE AND HOUR OF DEATH <i>Dec 11th 66 5 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE <i>md</i>		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		25-33	
00 2252 Sidney Ave		D. STREET ADDRESS (If rural, give location)		2252 Sidney Ave	
5. SEX <i>gr</i>	6. RACE <i>w</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>5/1/1880</i>	9. AGE (In years lost birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Leonard Forrester</i>		14. MOTHER'S MAIDEN NAME <i>Harriett A. Gable</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr Leonard M Meredith</i> ADDRESS <i>above</i>	
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>Cerebral Embolism</i> DUE TO (C) <i>C.C.V.D</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 day</i> <i>2 day</i> <i>16 year</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 1, 1966</i> to <i>12/11 1966</i> , that (I) (we) lost saw the deceased alive on <i>12/10 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paul Schunfeld</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/11/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Paul Schunfeld</i>		23D. ADDRESS <i>7305 Annapolis Rd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/14/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Not Christ Cem</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 13 1966</i>		25B. NAME OF REGISTRAR <i>R. J. E. E. E.</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc</i>	
				ADDRESS <i>991 St. Hollis 23-md</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12428</u>	
BIRTH NO. <u>66 12428</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mary Beckett</u>		2. DATE AND HOUR OF DEATH <u>Dec 10th 66</u> <u>8 A</u> M.	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>36 Franklin Square Hosp.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>1042 W. Lombard St.</u>			
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/12/1894</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife at home</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>James B. Slater</u>		14. MOTHER'S MAIDEN NAME <u>Alma B. Edwards</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) <u>✓</u>		16. SOCIAL SECURITY NO. <u>216-07-0335</u>		17. INFORMANT <u>Mr Timothy Slater</u> ADDRESS <u>6802 Ave Glenoak</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.01</u>		CAUSE OF DEATH (A) <u>arteriosclerotic heart disease</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 1965</u> to <u>Dec 10th 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 19 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Thomas B. Schreiber</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12-12-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MORRIS B. SCHREIBER</u>		23D. ADDRESS <u>1579 W. Lombard St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/13/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bethel Church Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Lovely Lancaster Va</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1966</u>			
25B. NAME OF REGISTRAR <u>John J. Bowman &amp; Son Inc.</u>		25C. FUNERAL DIRECTOR <u>John J. Bowman &amp; Son Inc.</u>		ADDRESS <u>23. Md.</u>	

1042 St. John's Bay

St. John's Bay

St. John's Bay

St. John's Bay

St. John's Bay

St. John's Bay

St. John's Bay

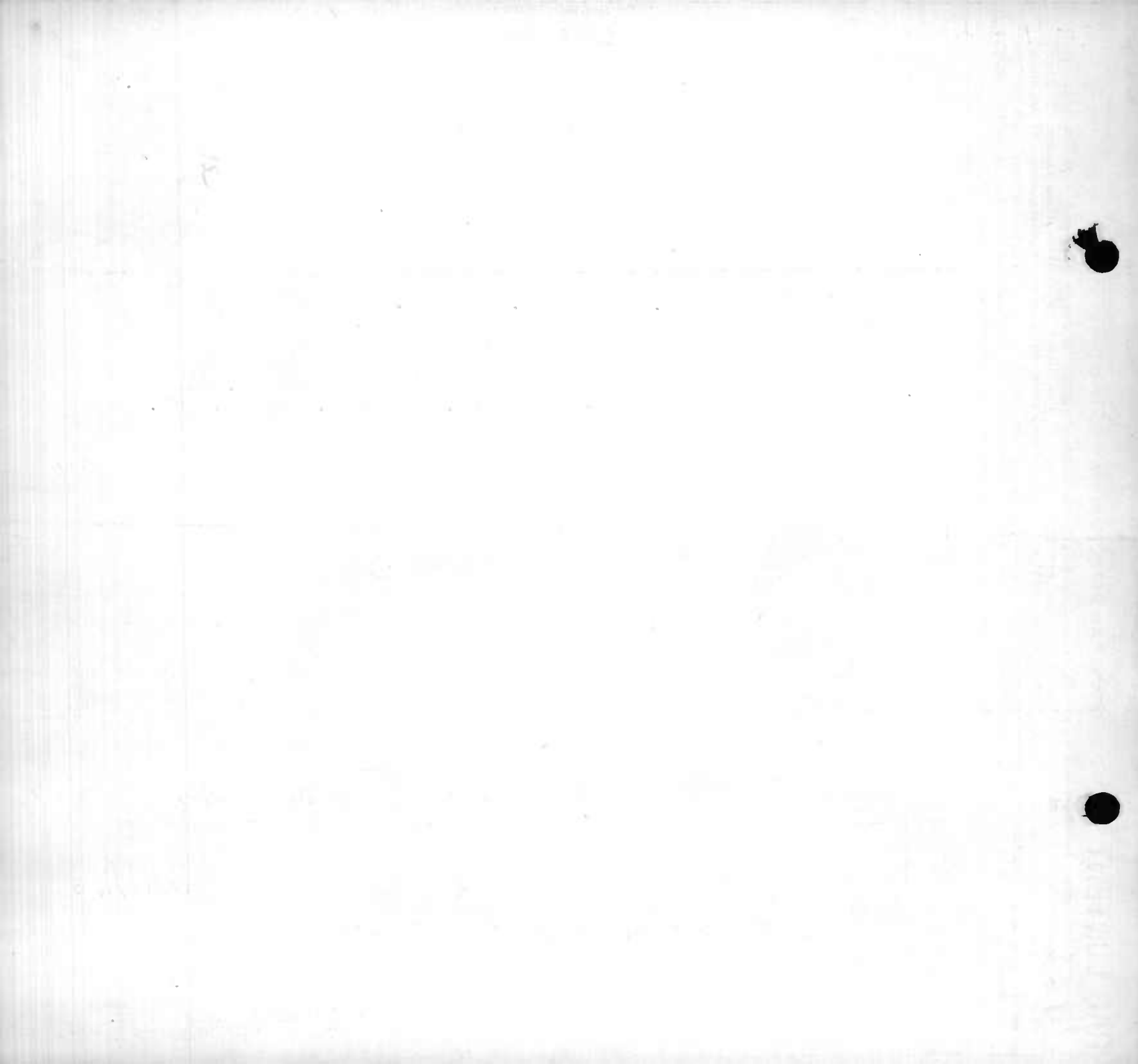
St. John's Bay

St. John's Bay

FUNERAL DIRECTOR: IMPORTANT

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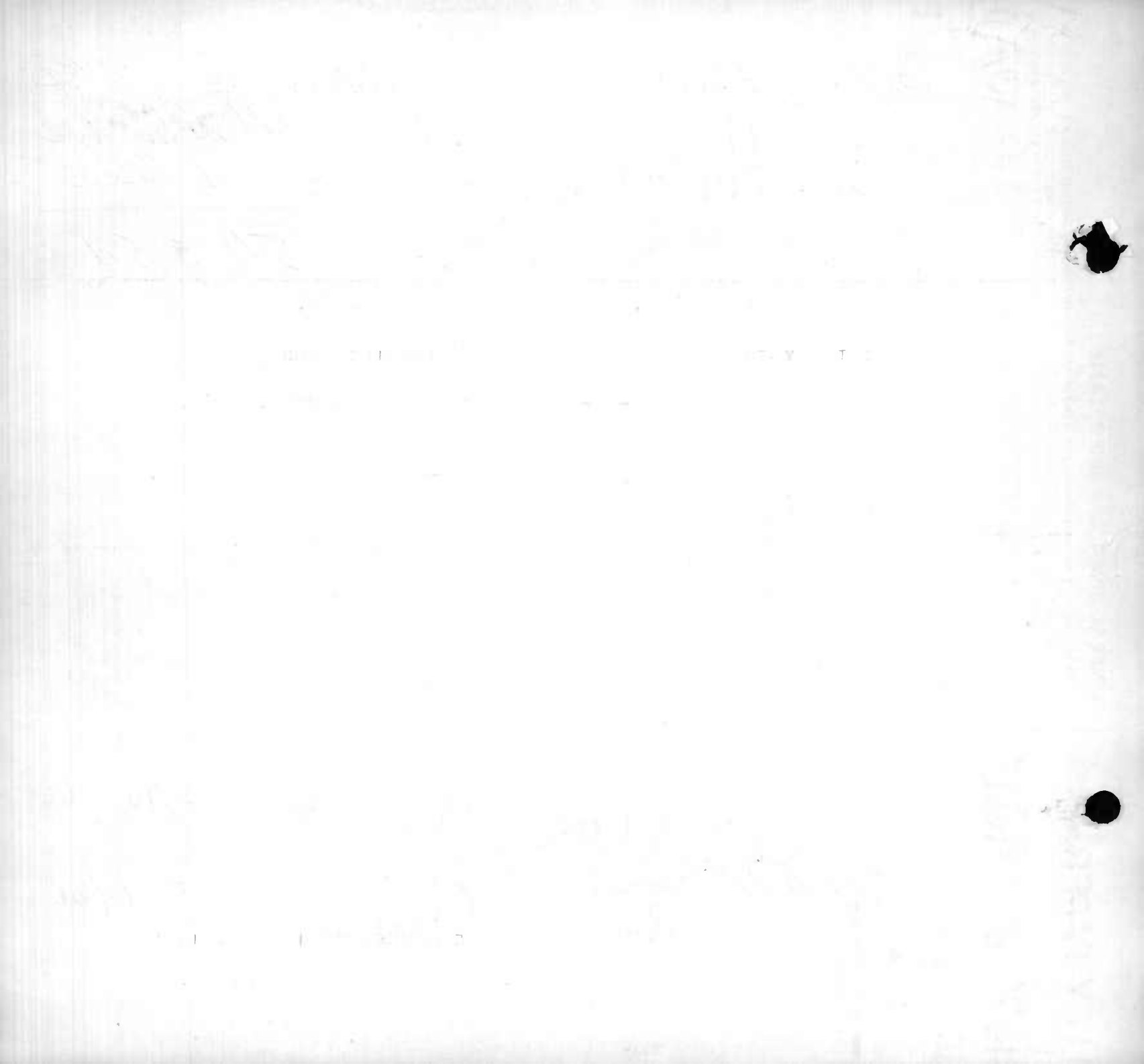
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12429</u>	
BIRTH NO. <u>66 12429</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ORIE E. BILES</u>		2. DATE AND HOUR OF DEATH <u>12-10-66</u>   <u>4.12</u> P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> C. STREET ADDRESS (If rural, give location) <u>1739 N. CASTLE STREET</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>MARRIED</u>	8. DATE OF BIRTH <u>3-13-97</u>	9. AGE (In years lost birthday) <u>69</u>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Burner</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Benna.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u>   <u>WW 1</u>			
16. SOCIAL SECURITY NO. <u>206-07-9091</u>		17. INFORMANT ADDRESS <u>1828 Wakona Rd. 21234</u> <u>Mrs. Albert J. Stuikis, dght.</u>			
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CARDIAC ARREST</u> DUE TO (B) <u>ACUTE MI</u> DUE TO (C) <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>40 MIN</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/>   Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> 19 <u>66</u> to <u>12/10</u> 19 <u>66</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>12/10</u> 19 <u>66</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <u>did</u> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>S. Mishkin</u>		M.D. Attending Phys. <input checked="" type="checkbox"/>   Med. Director <input type="checkbox"/>   Staff Phys. <input type="checkbox"/>		23B. DATE/SIGNED <u>12/10/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. Mishkin</u>		23D. ADDRESS <u>JHH</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/15/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cem</u>	
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>		ADDRESS <u>3331 Brehms Lane</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>66 12430</u>	
CERTIFICATE OF DEATH											
BIRTH NO. <u>66 12430</u>											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>Snyder, Robert Lee</u>		2. DATE AND HOUR OF DEATH <u>12-10-66 @ 8:45</u> M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution, give name before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>Baltimore</u> (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <u>1030 N. Collingwood Ave Baltimore, Md 21205</u>									
FULL NAME OF HOSPITAL OR INSTITUTION <u>John Hopkins Hospital</u>											
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7-5-82</u>		9. AGE (In years last birthday) <u>84</u>		If Under 1 Yr. Month Day Hour Min. <u>5 5 A 0</u>		If Under 24 Hrs. Hour Min. <u>5 5 A 0</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Helper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>ROBERT SNYDER</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE BORN</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-22-3513</u>		17. INFORMANT ADDRESS <u>Lula Bruns Snyder, wife, above</u>							
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>MI</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO						INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES/NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> 19 <u>66</u> to <u>12/10</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>W. Stan Wilson</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>12/10/66</u>			
23C. PHYSICIAN'S NAME (Type) <u>W Stan Wilson</u>				M.D. <u>THE J. HOPKINS HOSPITAL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/13/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Morel and Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, Inc. 2601 E. Madison St.</u>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		66 12431		66 12431	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
FRANCES CHARVAT LEHECKA			Dec. 11, 1966 7 a. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 3211 Ramona Ave.			A. STATE Md. 21213 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-03 D. STREET ADDRESS (If rural, give location) 3211 Ramona Ave.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
female	white	widowed	12/24/1882	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Saleslady		Murphy 5 & 10		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Charvat			Marie Hruby		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		220-14-9340		Emily Aime'e, McCarron-dght. above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO Coronary Occlusion Coronary Sclerosis (B) DUE TO Hypertension (C) DUE TO Arterio Sclerosis Heart		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Coronary Anemia, Malnutrition		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
		While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Dec 1 1966 to Dec 11 1966, that (I) (we) lost saw the deceased alive on Dec 11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Walter A. Anderson M.D.					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Walter Anderson M.D.				3001 Shannon Drive	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	12/14/66	Bohemian National Cem.	Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
DEC 13 1966	Robert E. Anderson	Schimunek Funeral Home, Inc. 3331 Brehms Lane			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 12432</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12432</b>	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>ELSIE JOHNSON</b>		
2. DATE AND HOUR OF DEATH <b>12-9-66 5:45 P.M.</b>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>46 Lutheran Hospital of Md.</b>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>16-07</b> D. STREET ADDRESS (If rural, give location) <b>3021 LITTLETON Rd.</b>			5. SEX <b>F</b> 6. RACE <b>C</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		
8. DATE OF BIRTH <b>1-4-19</b> 9. AGE (In years last birthday) <b>47</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			12. CITIZEN OF <b>U S A</b>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>?</b>		
17. INFORMANT ADDRESS <b>Hospital Chart</b>			18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>465X I Pulmonary embolism</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II Sinus Tachycardia and Bilateral Pneumonia</b>		
19. DATE OF OPERATION			20. AUTOPSY? (Yes or No) <b>Yes</b>		
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
25. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			26. HOW DID INJURY OCCUR?		
27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			28. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
29. SIGNATURE <b>Lucas C. Wydygajewski</b>			30. DATE SIGNED <b>12-9-66</b>		
31. PHYSICIAN'S NAME (Type) <b>LUCAS C. WYDYGAJEWSKI</b>			32. ADDRESS <b>Lutheran Hospital of Md.</b>		
33. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			34. DATE <b>12/13/66</b>		
35. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cemetery</b>			36. LOCATION (City, town, or county) (State) <b>A A County Md</b>		
37. DATE REC'D BY HEALTH DEPT.			38. NAME OF REGISTRAR		
39. FUNERAL DIRECTOR <b>Adolphus Halstead</b>			40. ADDRESS <b>1206 W North Ave</b>		

United

United States

United States

United States

United States

United States

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12433		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12433	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>HOWARD, Mobley</b>			2. DATE AND HOUR OF DEATH <b>12/7/66</b> <b>2:00 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lincoln Memorial Nursing Home</b> <b>27 N. CAREY ST.</b> <b>BALTIMORE, Md. 21223</b>			A. STATE <b>MD</b> B. COUNTY <b>9.9.C.</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>PASADENA</b> <b>52-00</b>		
D. STREET ADDRESS (If rural, give location) <b>Route 5 Box 507</b>					
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SEPARATED</b>	8. DATE OF BIRTH <b>3/10/95</b>	9. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>?</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>UNKNOWN</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>212-03-1538</b>		17. INFORMANT <b>Mrs Martha Johnson Pasadena Md</b>
18. <b>434.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>CONGESTIVE HEART FAILURE</b> (B) <b>INTERVAL BETWEEN ONSET AND DEATH</b> (C) <b>PNEUMONIA</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/25</b> 19 <b>66</b> to <b>12-7</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-7-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>HOANIS SEUNARINE</b> M.D.				23B. DATE SIGNED <b>12/7/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>HOANIS SEUNARINE</b> M.D.				23D. ADDRESS <b>980 WHITEHOCK ST, Pk 17</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>	
24D. LOCATION <b>A A County Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>			
25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>1206 W North Ave</b>			

Mr. J. H. Johnson, President

James H. Johnson  
President

1000 W. North Ave.  
Chicago, Ill.

Admission tickets for the  
concert at 1000 W. North Ave.  
Chicago, Ill.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

2. DATE AND HOUR PRONOUNCED DEAD

DELORES

STOKES

12-6-66

7:21 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1111 N. Centr al Avenue 21202

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

11/26/30

9. AGE (in years  
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U S A

13. FATHER'S NAME

Thaddus White

14. MOTHER'S MAIDEN NAME

Viola

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
Yes, no or unknown. (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Inesia Stewart 1313 Valley St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Aortic stenosis and regurgitation

~~XXXXXX~~

probably luetic

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/12/66

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 13 1966

Robert E. Fisher, M.D.

Adolphus Halstead 1206 W North Ave

11/26/70

Handed

Handed

Handed

Handed

Handed

Handed

ORIGINAL

Handed

Handed

Handed

Handed

Handed

BIRTH NO. **66 12435** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **66 12435**

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIE

WOODARD

(William  
Mooter)

2. DATE AND HOUR PRONOUNCED DEAD

December 4, 1966

4:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)37  
99  
Mercy Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1516 Holbrook Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Naomi Armstead 1839 Spring St

18.

E91C.O.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia by carbon monoxide  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Conflagration  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

house

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

1516 Holbrook Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

12-4-66

3:08 A.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Found on second  
floor of burning house.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, MD.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/12/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 13 1966

Adolphus Halstead 1206 W North Ave

Editor

South Carolina

My dear General Anderson

My dear General Anderson

Editor

Respectfully,  
John C. Calhoun



66 12436

BALTIMORE CITY HEALTH DEPARTMENT

66 12436

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DEAN J. MILLER

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1966 8:58 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)38  
99 University Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

426 N. Fremont Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 26, 1923

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tunstall Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Dean Miller

14. MOTHER'S MAIDEN NAME

Charity Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes Korean

16. SOCIAL  
SECURITY NO.

212-26-2724

17. INFORMANT

Thomas Miller 3422 Edmondson Ave.

ADDRESS

18.

420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

December 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/14/1966

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

Baltimore

(City, town or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1966

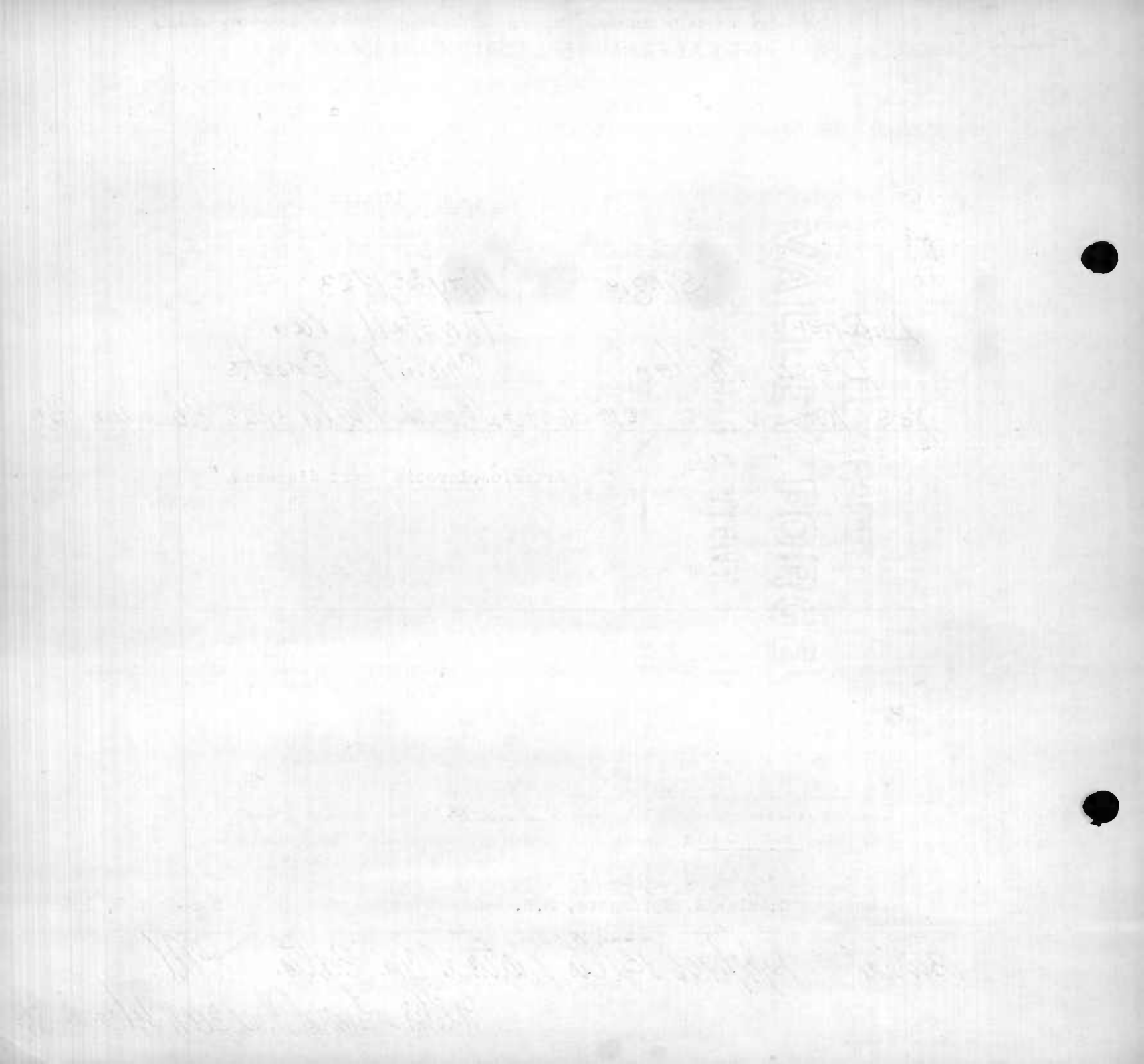
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

William Funeral Home 3149 Schroeder St.

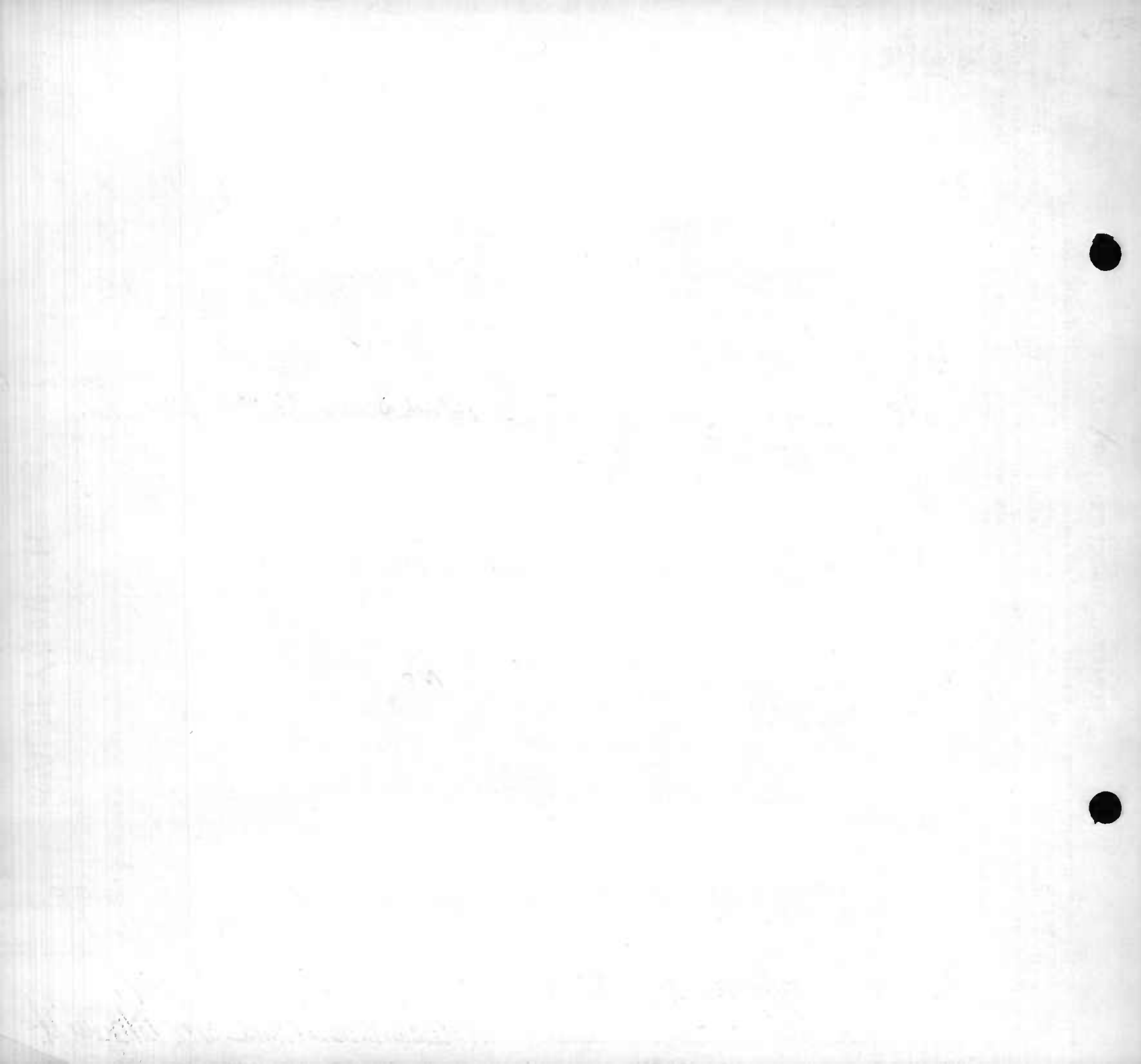
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12437		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12437	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Arthur A. Ward		2. DATE AND HOUR OF DEATH 12-7-66 1 7 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		A. STATE Md B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 18-02			
		D. STREET ADDRESS (If rural, give location) 1029 Clay St.			
5. SEX Male	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W.	8. DATE OF BIRTH 7-26-1900	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Illinois U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Nathan Ward		14. MOTHER'S MAIDEN NAME Martha Washington	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219167603A		17. INFORMANT ADDRESS Agnes Scurry Box 943 Spencer Rd. Baltimore Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of lung		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 5 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-10-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of lung		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-29 1966 to 12-7 1966, that (I) (we) last saw the deceased alive on 12-6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carlos Boetsch M.D.				23B. DATE SIGNED 12-7-66	
23C. PHYSICIAN'S NAME (Type) Carlos Boetsch M.D.				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/66		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
24D. LOCATION Cedar Hill Md.		24E. DATE REC'D BY HEALTH DEPT. DEC 13 1966		24F. NAME OF REGISTRAR R. E. E. Johnson	
24G. FUNERAL DIRECTOR Williams Funeral Home		24H. ADDRESS 3199 Schenck St.			



66 12438

BALTIMORE CITY HEALTH DEPARTMENT

66 12438

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE TOWNSLEY

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1966 4:45 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

620 Sterling Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 18, 1921

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

HENRY TOWNSLEY

14. MOTHER'S MAIDEN NAME

LONOR BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)

Yes

W.W. 2

16. SOCIAL  
SECURITY NO.

212-16-6410

17. INFORMANT

Catherine Brown 620 Sterling St.

ADDRESS

18. 331X 5811

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Intracerebellar hemorrhage  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Lamenc's cirrhosis

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Dec. 14, 1966

23C. NAME OF CEMETERY OR CREMATORY

Balto. National Cem.

23D. LOCATION

Balto.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1966

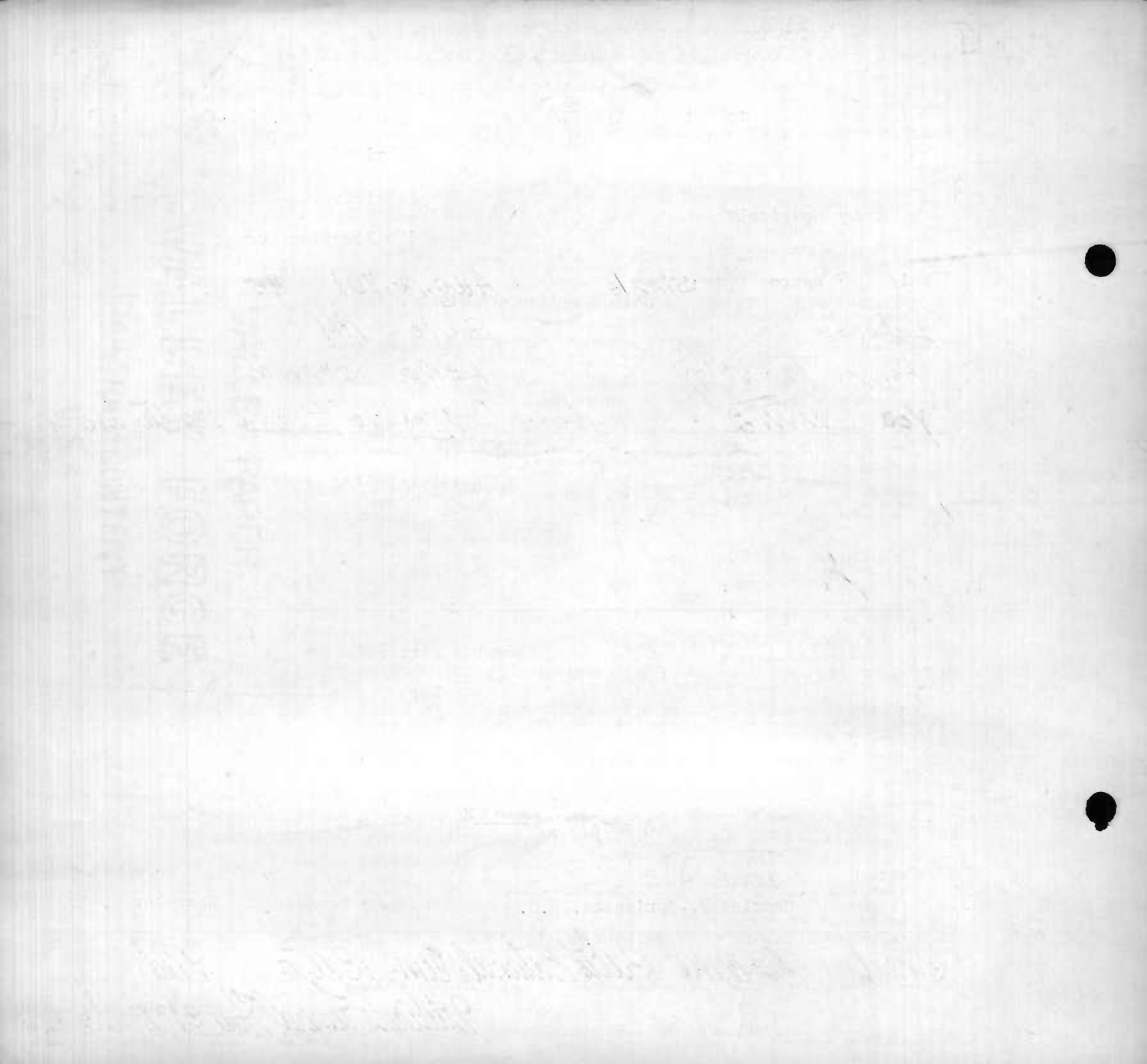
24B. NAME OF REGISTRAR

Charles E. Felt

24C. FUNERAL DIRECTOR

Williams Funeral Home 3198 S. Howard St.

ADDRESS



66 12439

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12439

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JACOB S. ZIMMERMAN

2. DATE AND HOUR PRONOUNCED DEAD

12-12-66

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

505 N. CHAPEL GATE LANE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

505 N. Chapel Gate Lane 21229

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 21, 1925

9. AGE (In years  
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

District Manager

10B. KIND OF BUSINESS OR INDUSTRY

Equitable Life Assur.  
Society

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Louie A. Zimmerman

14. MOTHER'S MAIDEN NAME

Juanita J. Engle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL  
SECURITY NO.

215-28-2057

17. INFORMANT

ADDRESS

Mrs. Joann Zimmerman same address

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hanging  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

505 N. Chapel Gate Lane

21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)  
12 12 '66 4:00 AM

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Found hanging from 4"  
water pipe in basement of home

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-12-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/15/1966

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1966

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

Wm. J. Fickner &amp; Sons

ADDRESS

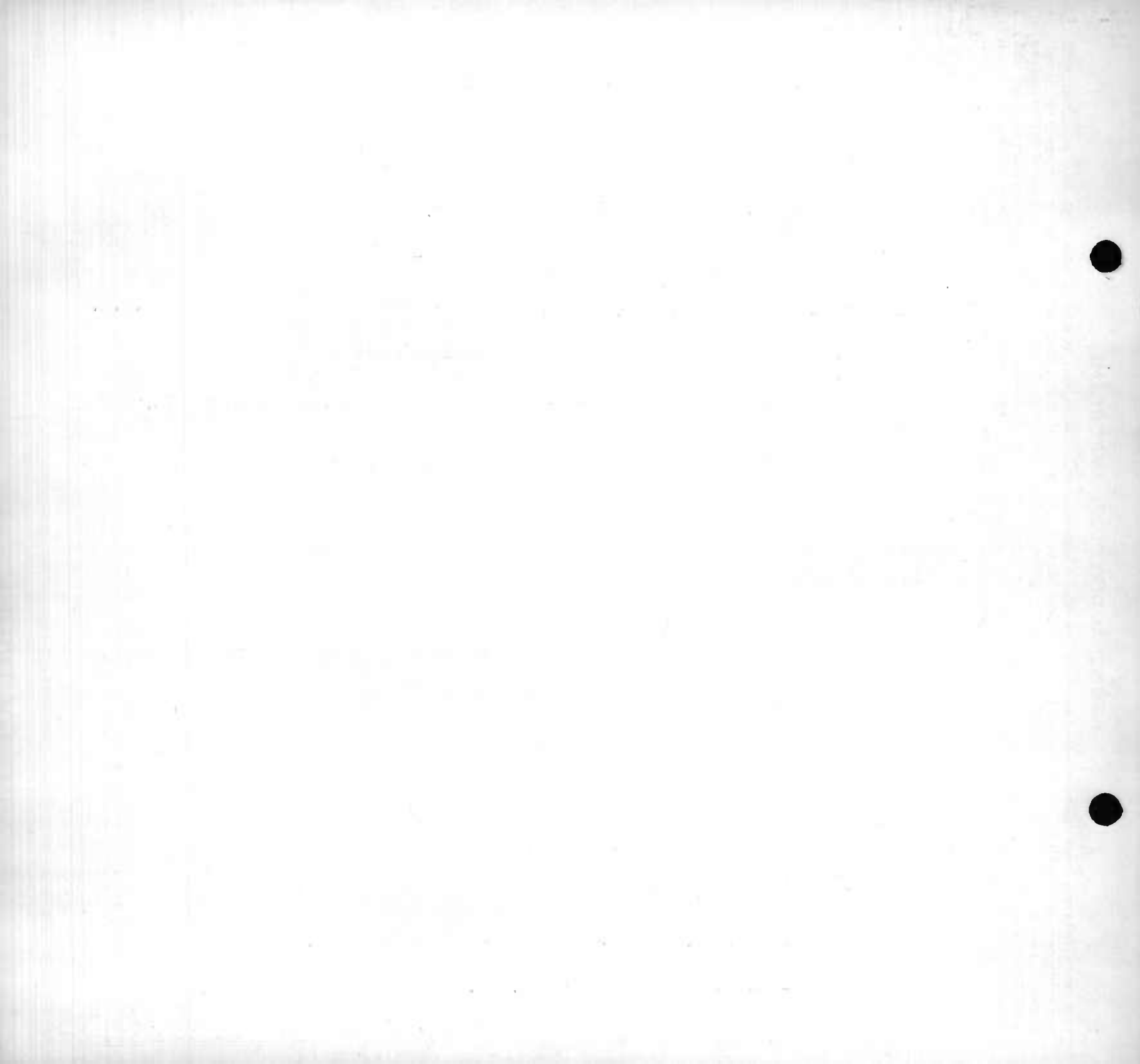
Balto. Md.  
North H.A.





MEDICAL CERTIFICATION

VS 150-REV. 1/1/65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

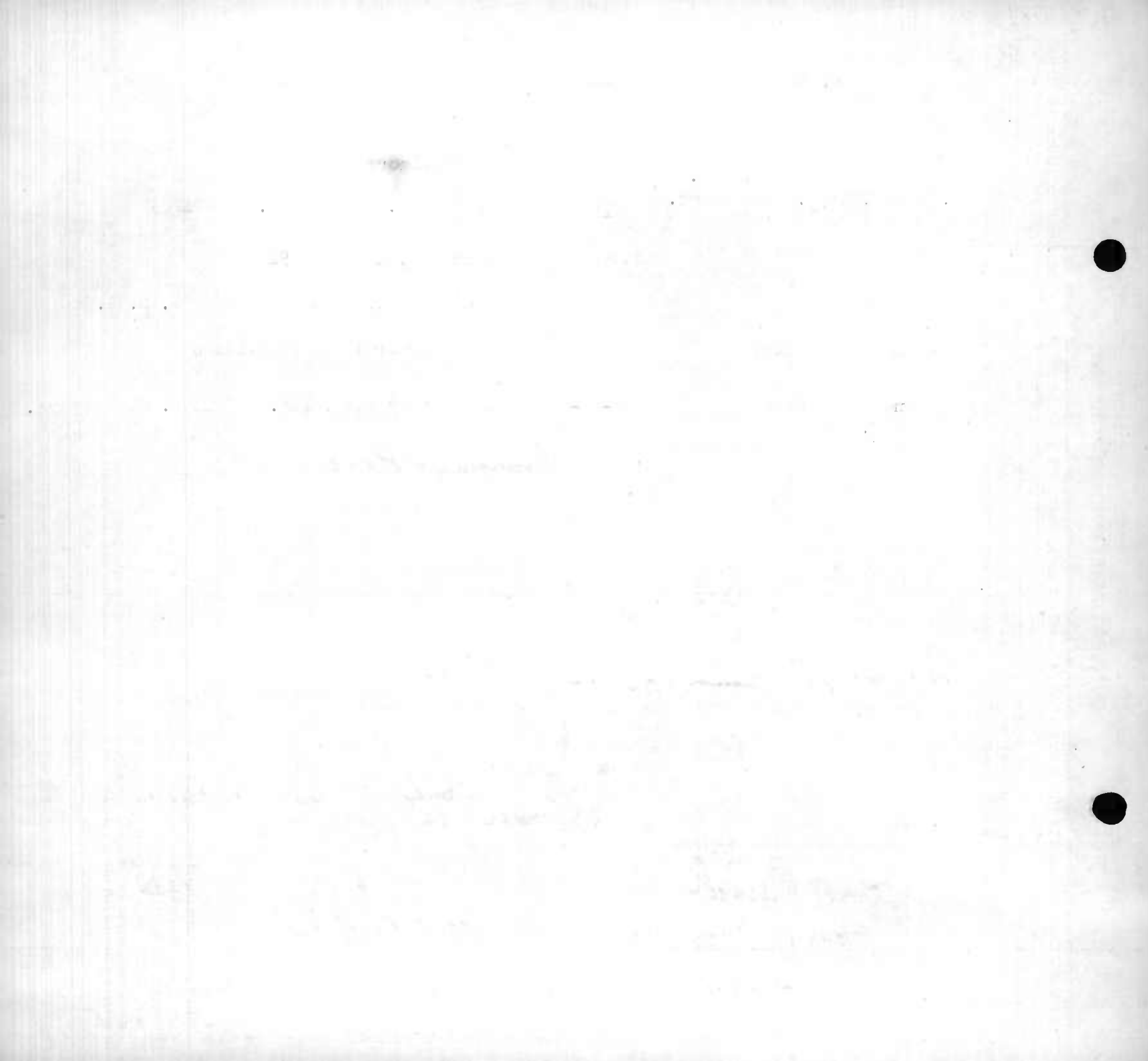
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 12441		CERTIFICATE OF DEATH		66 12441	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Michael G. Lohrmann		12/8/66 11:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Maryland General Hospital		Md.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		9-03	
		D. STREET ADDRESS (If rural, give location)			
		603 E. 37th St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	W	Widowed	11/16/82	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Printer - Retired		Commercial Printing	Md.	U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
G. Michael Lohrmann		Louise Sidmeyer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give where)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		None	Mr. Arthur Lohrman same address		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
177X I		(A) Malignancy of Prostate Suspected		unknown	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that <del>this</del> (this hospital) attended the deceased from 12/5 19 66 to 12/8 19 66, that <del>we</del> (we) last saw the deceased alive on 12/8 19 66 and that <del>in</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I <del>was</del> (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Bernard du Buy				12/8/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Bernard du Buy		Maryland Genl. Hosp.			
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	12/12/1966	Loudon Park Cemetery	Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
DEC 13 1966	Robert E. Johnson	Wm. J. Schuler & Sons		Baltimore, Md.	

stated to

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12442				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12442	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John Milne				2. DATE AND HOUR OF DEATH December 10, 1966 4:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Wesley Home, Inc. 2211 W. Rogers Ave. Baltimore, Maryland 21209				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2211 W. Rogers Ave. 21209			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH March 30, 1875	9. AGE (In years last birthday) 91	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Liverpool, England		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Milne				14. MOTHER'S MAIDEN NAME Margaret Davidson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 220-44-6870 T		17. INFORMANT ADDRESS The Wesley Home, Inc. 2211 W. Rogers Ave.			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Carcinoma of Bladder DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 10 July 66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Bladder		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4 July 1966 to 10 December 1966, that (I) (we) last saw the deceased alive on 7 December 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John W. Barnaby				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12 Dec 66	
23C. PHYSICIAN'S NAME (Type) JOHN W. BARNABY				23D. ADDRESS M.D. 1531 E. North Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/1966		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1966		25B. NAME OF REGISTRAR Wm. J. Finkbeiner		25C. FUNERAL DIRECTOR Wm. J. Finkbeiner & Sons		ADDRESS Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>66 12443</u>					
BIRTH NO. <u>66 12443</u>		M.E. CASE NO.								
1. NAME OF DECEASED (Type or Print) <u>KAHN, TEROME William</u>					2. DATE AND HOUR OF DEATH <u>12-11-66</u> <u>6:25 A.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 SINAI HOSP.</u>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>13-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>901 LAKE DR.</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>12-6-88</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Consultant</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Artist Supply K &amp; E</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>William Kahn</u>					14. MOTHER'S MAIDEN NAME <u>Clara Schoolhouse</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>212-03-7919</u>		17. INFORMANT <u>HOSP. CHART.</u>			ADDRESS		
18. <u>331 X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>CEREBROVASCULAR ACCIDENT 30 DAYS.</u> DUE TO (B) <u>GENERALIZED ATHEROSCLEROSIS</u> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD ECHF</u>										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <u>11-10</u> 19 <u>66</u> to <u>12-11</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-11</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Alvin Schachter</u> M.D.					23B. DATE SIGNED <u>12-11-66</u>					
23C. PHYSICIAN'S NAME (Type) <u>ALVIN SCHACHTER</u> M.D.					23D. ADDRESS <u>SINAI HOSP.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/13/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hebrew Friendship Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Galt, M.D.</u>			25C. FUNERAL DIRECTOR <u>Wm. J. Zuker-Sons</u>			ADDRESS <u>Balto, Md.</u>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12444	
BIRTH NO. 66 12444		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>James Kenneth POTEAT</b>		2. DATE AND HOUR OF DEATH <b>2 Dec 66 630 P M.</b>	
3. PLACE OF DEATH <b>IN BALTIMORE, MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>USA</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>3024 N. Calvert</b>			
5. SEX <b>M</b>	6. RACE <b>Cauc</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2/13/87</b>	9. AGE (In years last birthday) <b>79</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Mgr.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Brown &amp; Williams Tobacco Co.</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James P. POTEAT</b>		14. MOTHER'S MAIDEN NAME <b>Emily Moore</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <b>584 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bowel Perforation (? Intestinal)</b>		(A) DUE TO <b>JAUNDICE &amp; ACUTE CHOLANGITIS</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Common Duct Stone &amp; Exploration</b>			
(C) DUE TO <b>High Output Renal Failure</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>11-17-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholelithiasis</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>31 OCT</b> 19 <b>66</b> to <b>2 Dec</b> 19 <b>66</b> , that (1) <del>we</del> last saw the deceased alive on <b>2 Dec</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above. (I) <del>we</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael B. Flynn</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>2 Dec 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Michael B. Flynn</b> M.D.				23D. ADDRESS <b>Univ. Hosp. Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>12-12-66</b>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>		25B. NAME OF REGISTRAR <b>P.O. &amp; S. Flynn</b>	
25C. FUNERAL DIRECTOR <b>UNIVERSITY MEDICAL SCHOOL</b>		25D. ADDRESS <b>UNIVERSITY MEDICAL SCHOOL</b>		25E. ADDRESS <b>UNIVERSITY MEDICAL SCHOOL</b>	

Classroom of History

302nd St (subway)  
Dobsonville

Mr. (last name)

James P. Poteat  
Factory Mr. P. Poteat

Emily Poteat  
2/1/87

1887

James Poteat (C. Poteat)  
James Poteat (C. Poteat)

Common Out Store - Poteat  
High Street Poteat

11-12-86 (Poteat)

31 Oct 86

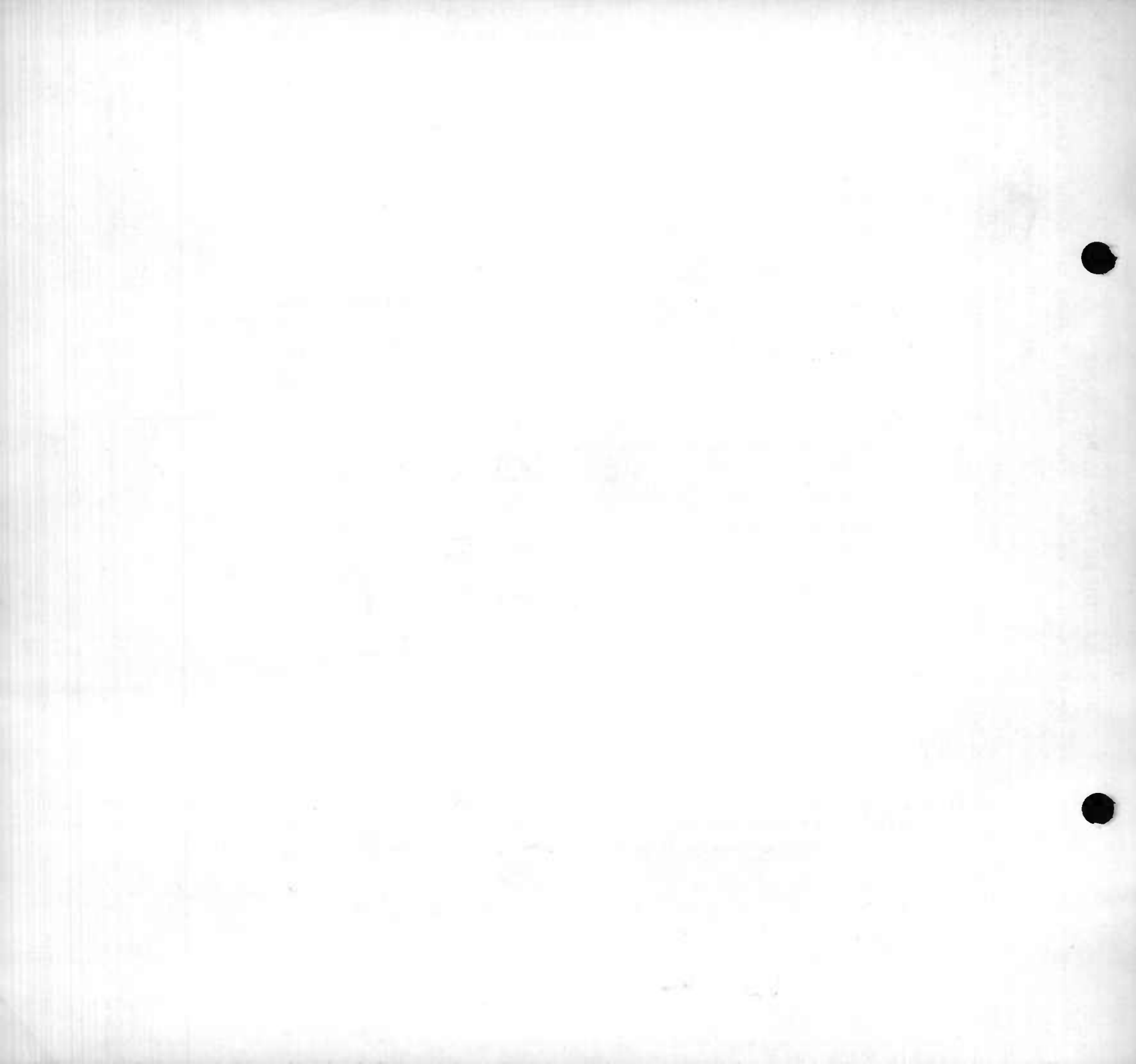
James P. Poteat

James Poteat

# FUNERAL DIRECTOR: IMPORTANT

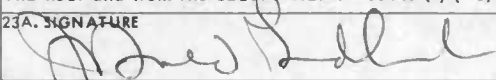
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

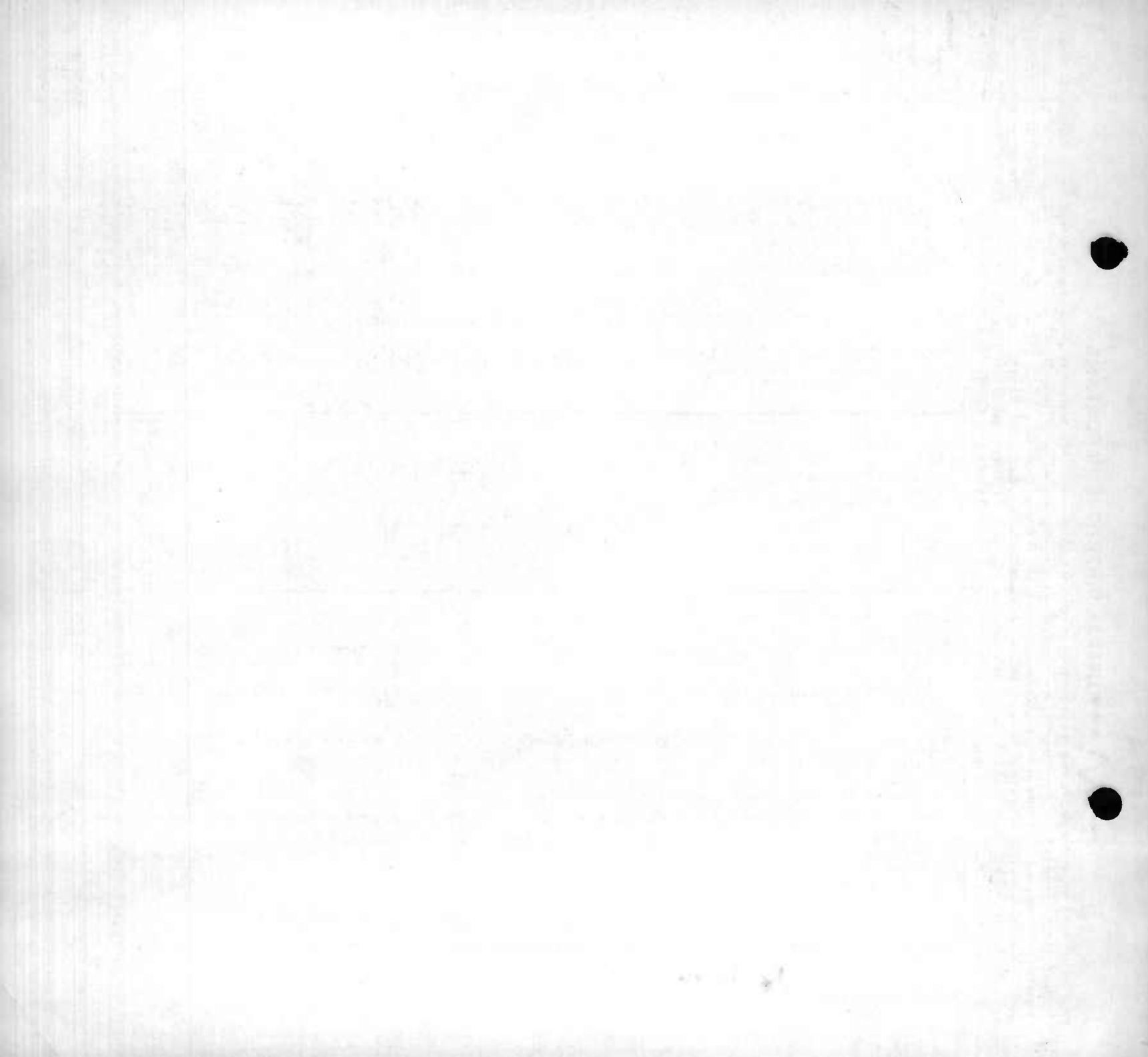
BIRTH NO. 66 27277 66 66 12445				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12445	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BABY GIRL JESSUP</b>				2. DATE AND HOUR OF DEATH <b>12/11/66 4 30 A M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <b>MD.</b>		B. COUNTY	
<b>38 UNIV. HOSP.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>1552 N. FREEMONT AVE. BALT.</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>12/9/66</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD POWELL</b>				14. MOTHER'S MAIDEN NAME <b>BETTY LOUISE JESSUP</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.	17. INFORMANT <b>CHART</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) <b>IMMATURITY</b>		<b>LIFE</b>	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>12-9-1966</b> to <b>12-11-66</b> 19 that (we) lost saw the deceased alive on <b>12/11/66</b> 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Mary E. Keeler</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/11/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARY E. KEELER</b>				23D. ADDRESS <b>UNIV. HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-12-66</b>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>		25B. NAME OF REGISTRAR <b>R. E. JESSUP</b>		25C. FUNERAL DIRECTOR		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66-25550 66 12446		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12446 4	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>M.E. CASE NO.</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>BABy BOY DUNCAN</b>			2. DATE AND HOUR OF DEATH <b>11/25/66 11:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 MARYLAND GENERAL HOSP.</b>			A. STATE <b>MO.</b> B. COUNTY <b>BALTO. CO.</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. #22 53-00</b>		
			D. STREET ADDRESS (If rural, give location) <b>4027 ST. AUGUSTINE LANE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>INFANT</b>	8. DATE OF BIRTH <b>11/25/66</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>1 22</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>PATRICK FRANCIS DUNCAN</b>			14. MOTHER'S MAIDEN NAME <b>BARBARA JOAN DOUGLAS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>MOTHER</b>		ADDRESS <b>SAME</b>
18. <b>773.5 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PREMATURITY</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>INTERVAL BETWEEN ONSET AND DEATH 1 hr 20 min</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPST? (Yes or No) <b>0</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	

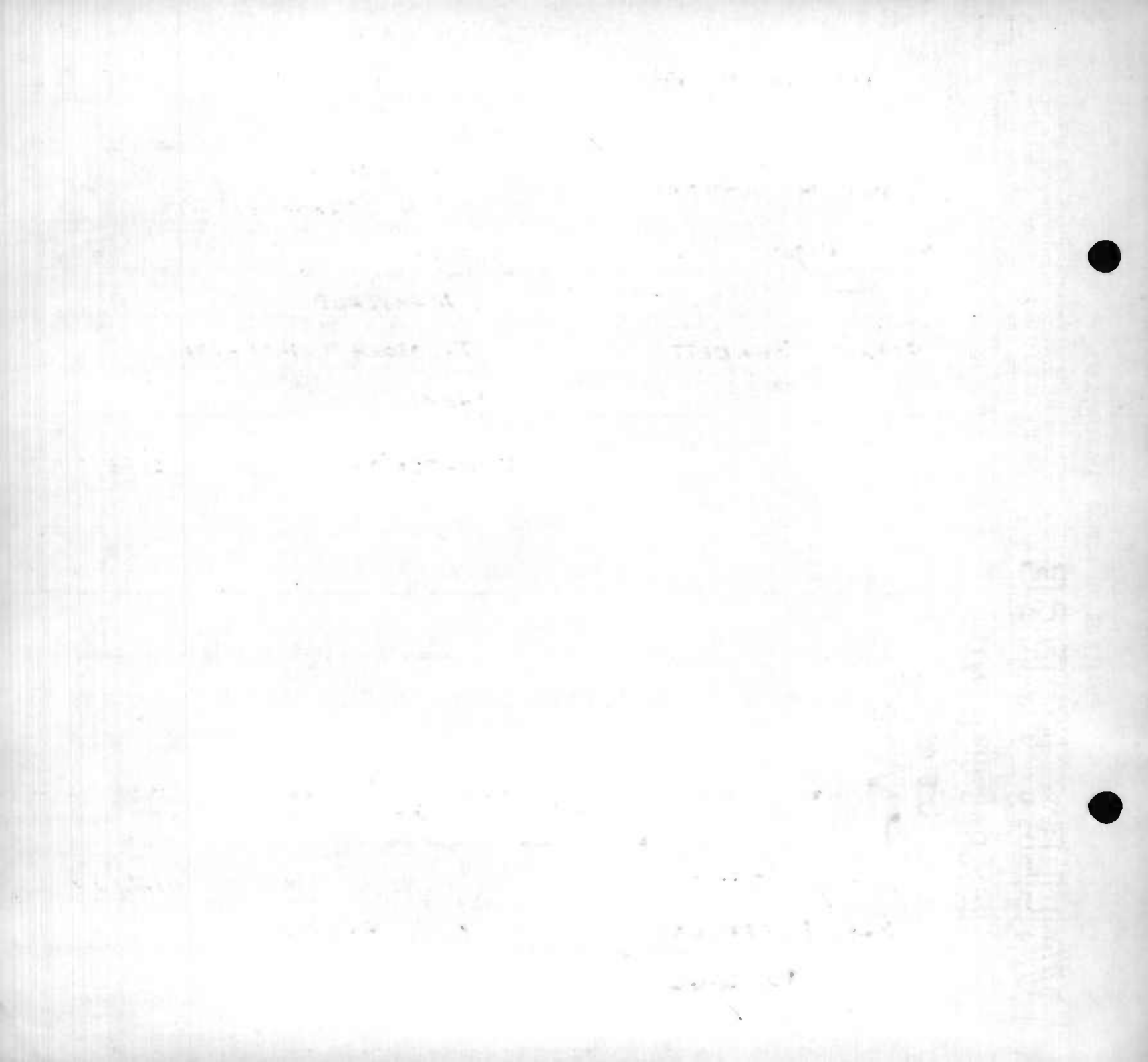


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12447</u>	
BIRTH NO. <u>66 12447</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BABY BOY McFadden</u>		2. DATE AND HOUR OF DEATH <u>11/29/66</u> <u>9 50</u> <u>A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIV. OF HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>314 N. SCHROEDER ST.</u>			
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) _____	8. DATE OF BIRTH <u>11/29/66</u>	9. AGE (In years last birthday) _____	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <u>4 35</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>GERALD BENNETT</u>			
14. MOTHER'S MAIDEN NAME <u>THEODORA McFADDEN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHART</u>			
18. <u>776 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>IMMATUREITY</u> DUE TO _____ (B) _____ DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>LIFE - 4 35</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>11/29</u> 19 <u>66</u> to <u>11/29</u> 19 <u>66</u> , that (we) last saw the deceased alive on <u>11/29</u> 19 <u>66</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mary E. Keeler</u> M.D.				23B. DATE SIGNED <u>11/29/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARY E. KEELER</u>				23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-12-66</u>		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BOARD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Sisk</u>		25C. FUNERAL DIRECTOR ADDRESS	







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66-24956 66 12448</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 12448</u>	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Malone</u>			2. DATE AND HOUR OF DEATH <u>11/19/66</u> <u>12:30 AM.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ 8. COUNTY _____		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University Hosp</u>			C. CITY OR TOWN (If outside city limits, write R.U.R.A. and give township) <u>Balt # 30 15-04</u>		
			D. STREET ADDRESS (If rural, give location) <u>2101 N. Fulton Ave</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>11/17/66</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min. <u>2 7</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Malone</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <u>776X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <u>immaturity</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>✓</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> 19 <u>66</u> to <u>11/19</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. Rosenstein</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/19/68</u>
23C. PHYSICIAN'S NAME (Type) <u>A. Rosenstein</u>			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>12-1-66</u>	24C. NAME OF CEMETERY or CREMATORY <u>St. Mary's</u>		24D. LOCATION (City, town, or county) (State) <u>OK</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHO</u>	

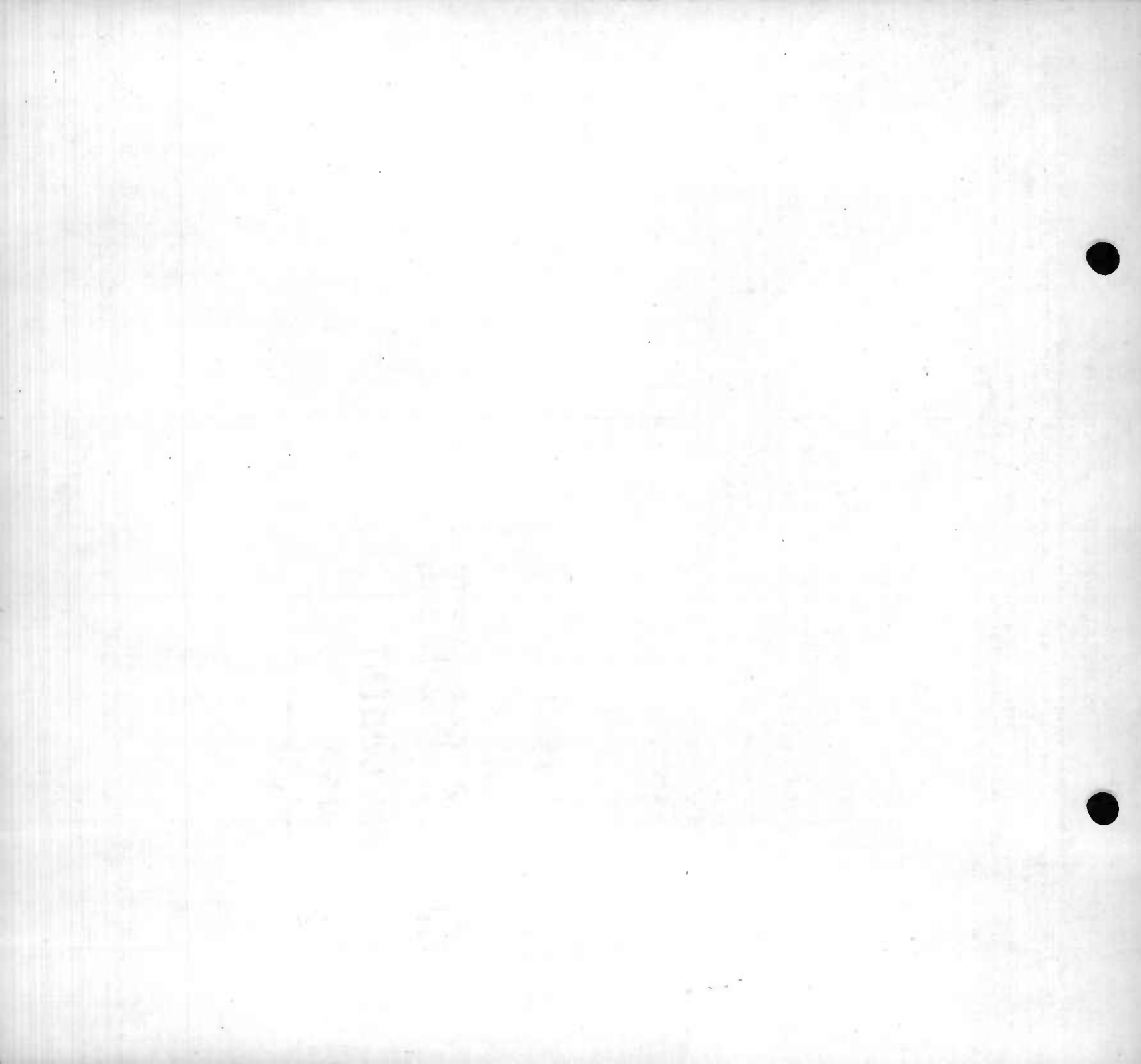
2100 1 1/2 1/2 1/2

2100 1 1/2 1/2 1/2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

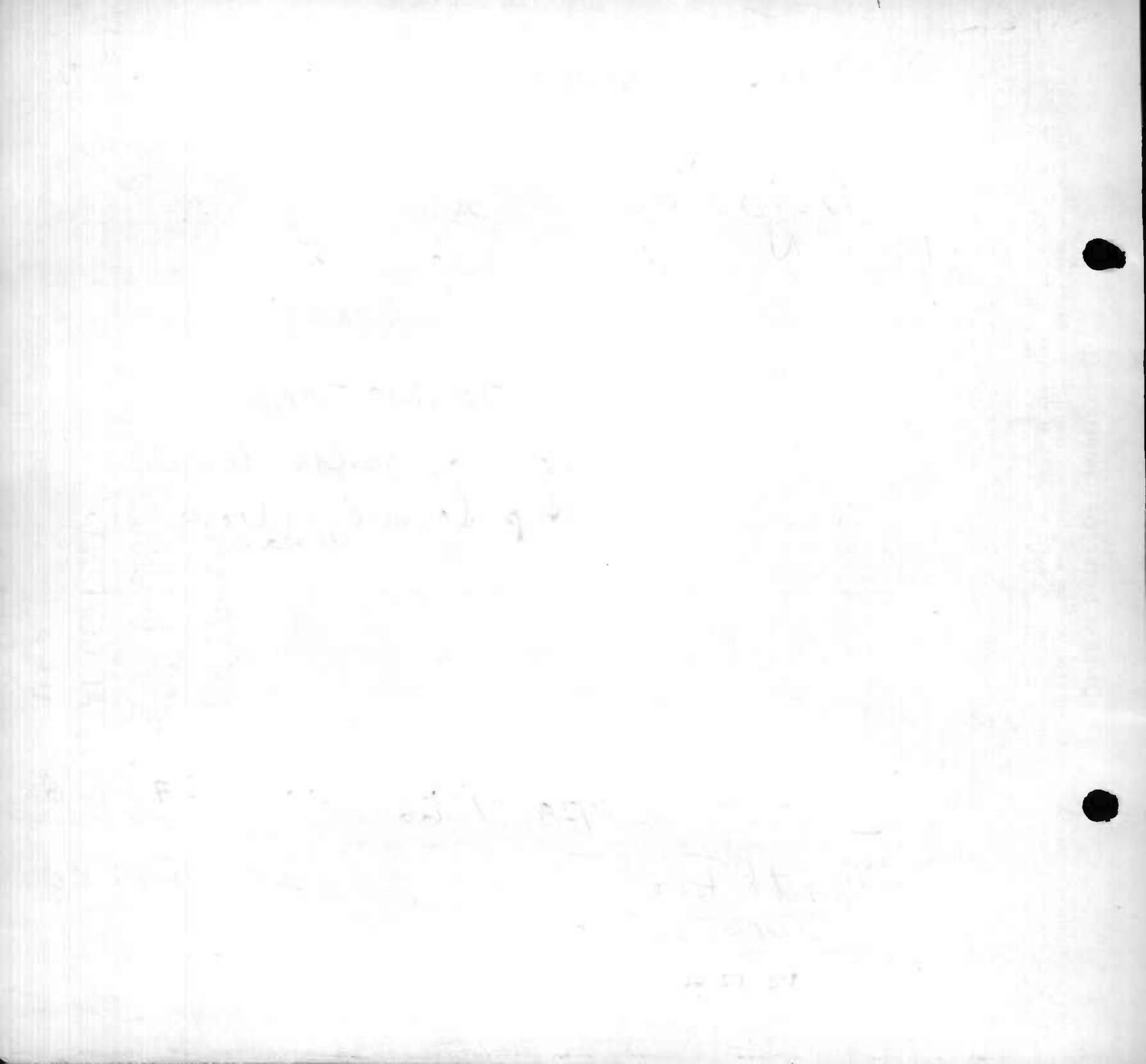
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12449</b>	
BIRTH NO. <b>66-24446</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>11/20/66 1 600 A.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>FISHER, BABY GIRL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY Hosp.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1427 ARGYLE AVENUE</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>11/12/66</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	9. AGE (In years last birthday) <b>8</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>CHRISTINE FISHER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>CHART</b>
18. <b>776 X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>IMMATURITY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/12</b> 19 <b>66</b> to <b>11/20</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/20/66</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Mary Beth Keeler</b>		23B. DATE SIGNED <b>11/20/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARY BETH KEELER</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL, MARYLAND</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>12-12-66</b>		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>		24D. LOCATION (City, town, or county) (State) <b>MORTUARY SERVICE - BALD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

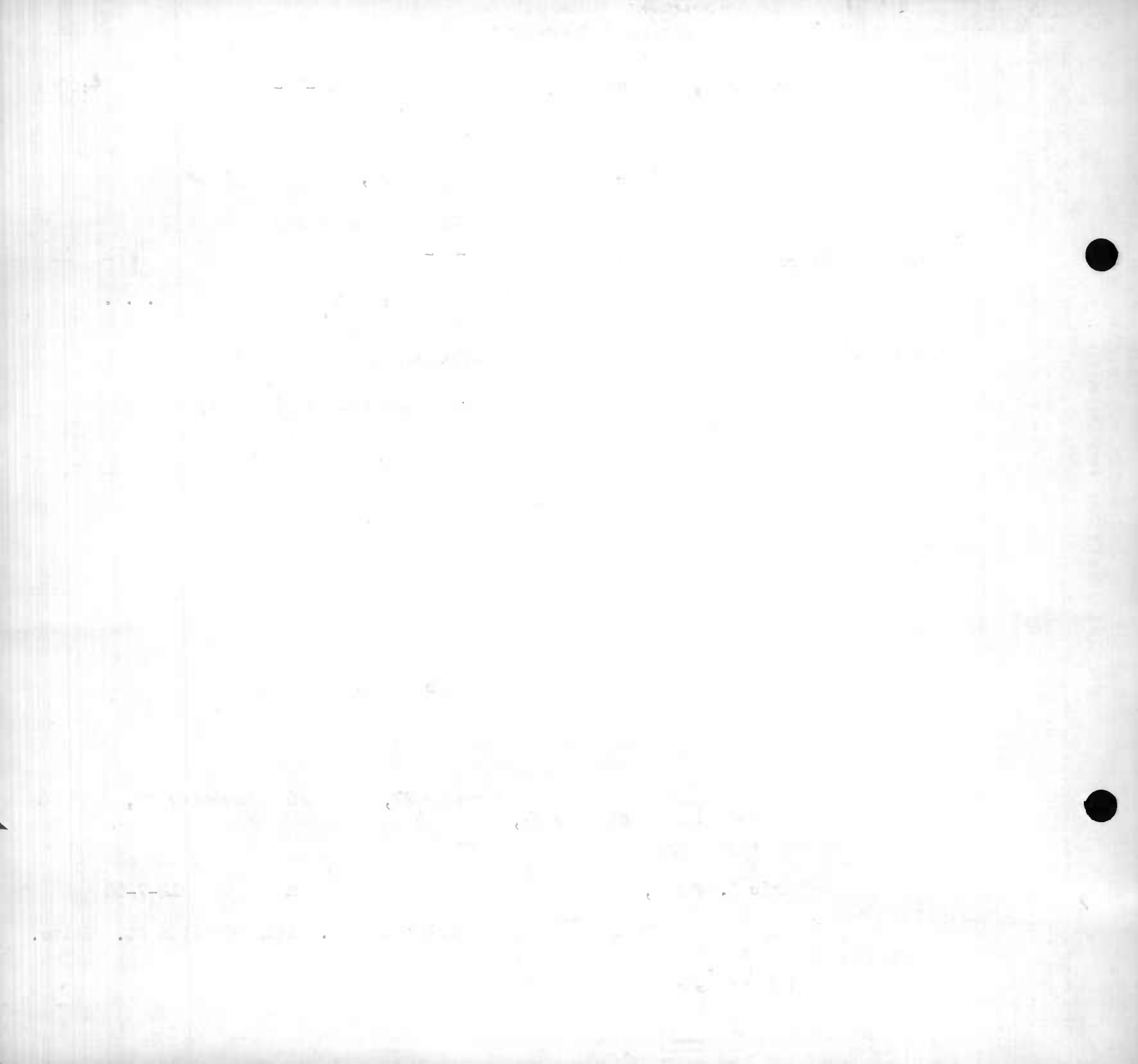
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Baltimore City Health Department	
BIRTH NO. 66 12450				Registered No. 66 12450	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>SPRIGGS, Melanee</b>		2. DATE AND HOUR OF DEATH <b>11-29-66 16<sup>15</sup> PM M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIV HOSP. BALTO., MD.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>			
		D. STREET ADDRESS (If rural, give location) <b>2800 PRESSTMAN ST.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>1-2-30</b>	9. AGE (In years last birthday) <b>36+</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>JANNIE TANNER S/A</b>	
18. <b>443 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular disease</b>		CAUSE OF DEATH <b>Hypertensive cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/29/66</b> to <b>11/29/66</b> , that (I) (we) last saw the deceased alive on <b>11/29/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stuart C. Fine</b> M.D.				23B. DATE SIGNED <b>11-29-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>STUART C. FINE</b> M.D.				23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-12-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BOARD</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12451		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12451	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Strickland, Baby		11-27-66		9:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		A. STATE Maryland			
(If not in hospital or institution, give street address or location)		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		D. STREET ADDRESS (If rural, give location)		17-02	
		1238 Argyle Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	Negro	Single	11-27-66	2 35	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Otha Strickland		Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Betty Strickland (mother) SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
776X I		Prema Furi ty (21b.)		245 mins.	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from November 27, 19 66 to November 27, 19 66, that (I) (we) last saw the deceased alive on November 27, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Eric L. White, M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				12-7-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Provident Hosp. 1514 Division St. Balto.					
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
12-12-66				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 13 1966		R. E. Taylor		MORTUARY SERVICE - BOND	

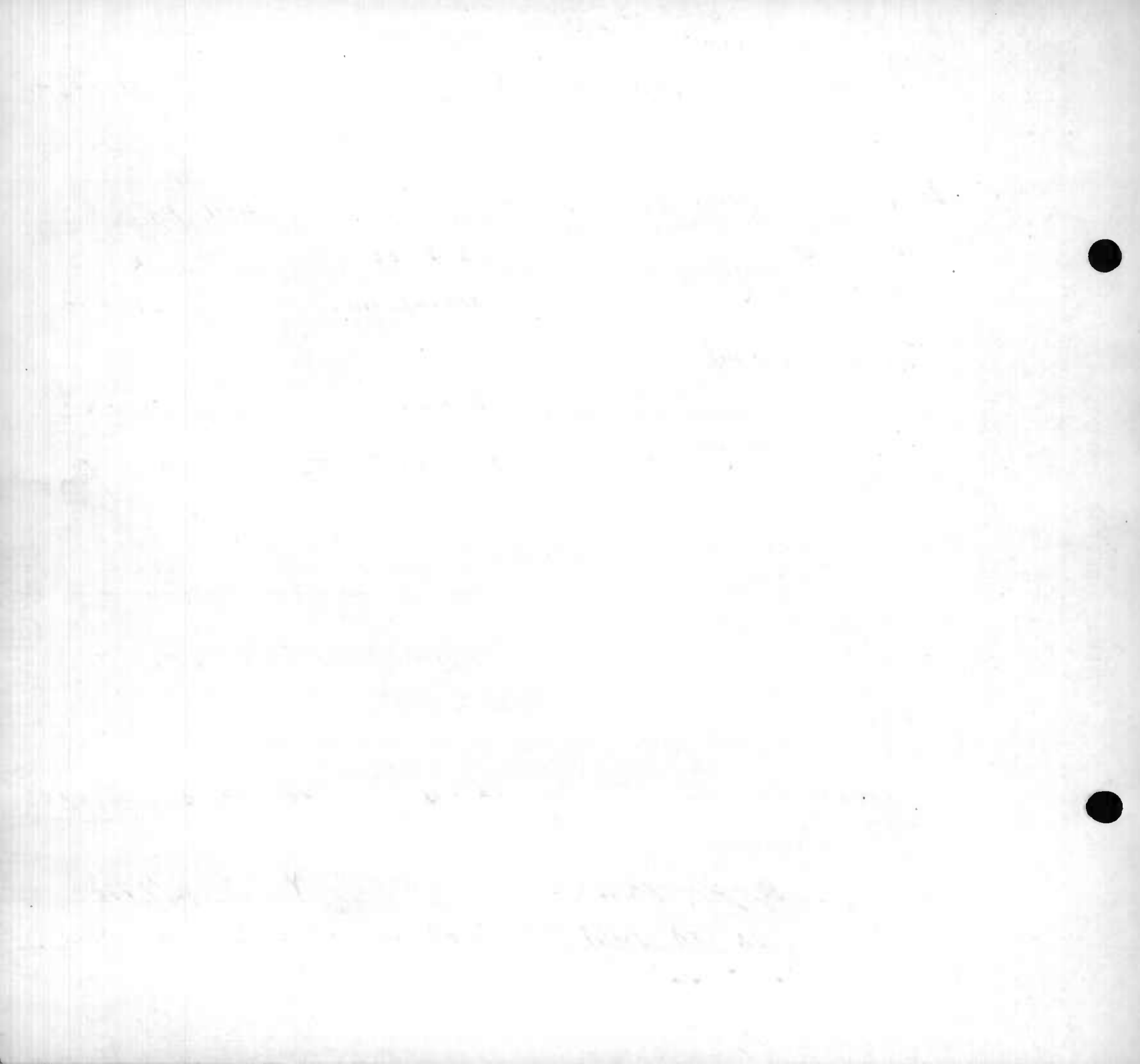




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12452 66-25902				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12452 4	
M.E. CASE NO. 395-2890				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby <del>Deborah</del> Ward "A"				2. DATE AND HOUR OF DEATH 12-6-66 11:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
Lutheran Hospital of Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		25-32	
				D. STREET ADDRESS (If rural, give location) 1110 Cherry Hill Rd.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-4-66	9. AGE (In years last birthday) 2	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe L. Ward				14. MOTHER'S MAIDEN NAME DOLORES WARD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		ADDRESS Same	
18. 776 x 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO Prematurity		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-4-66 to 12-6-66, that (I) (we) last saw the deceased alive on 12-4-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/6/66	
23C. PHYSICIAN'S NAME (Type) COON JA KIM M.D.				23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-12-66		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) State	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1966		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-25703 66 12453		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12453	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BABY GIRL "B" WARD</b>		2. DATE AND HOUR OF DEATH <b>12/5/66 12:45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
5. SEX <b>F</b>		6. RACE <b>C</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JOE L. WARD</b>		14. MOTHER'S MAIDEN NAME <b>DOLORES WARD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MOTHER</b>	
18. <b>776 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Immaturity</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>✓</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/4</b> 19 <b>66</b> to <b>12/5/66</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/5/66</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>F. S. Reroma</b>		23B. DATE SIGNED <b>12/5/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. S. Reroma</b>		23D. ADDRESS <b>M.D.</b>		23E. MEDICAL DIRECTOR <b>Med. Director</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>12-12-66</b>		24B. DATE <b>12-12-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>12-12-66</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BOLD</b>	

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2-165

66 12454

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12454

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
EUGENIA LEBRAUN				12-12-66 12:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 2608 N. CALVERT STREET				A. STATE Maryland			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-03			
				D. STREET ADDRESS (If rural, give location) 2608 N. Calvert Street 21218			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/5/80	9. AGE (In years last birthday) 86	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gene Depardiu				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Balto. Md. 21202 m Paulett Bradstock 2608 N. Calvert St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  422.1 I Arteriosclerotic cardiovascular disease  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Partial		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Partial			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Cremation				23B. DATE 12/14/66		23C. NAME of CEMETERY or CREMATORY Green Mount Crematory	
				23D. LOCATION Balto. Md.		23E. LOCATION (City, town, or county) (State)	
24A. DATE REC'D BY HEALTH DEPT. DEC 13 1966		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR Balto. Md. 21202 m Wm. Cook-Brooks F. H. 1217 St. Paul St.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12455				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12455	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>MAY L. MACLENNAN</b>				2. DATE AND HOUR OF DEATH <b>December 9, 1966 2:20 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL of BALTIMORE, INC.</b> <b>42</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>B MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 27-13</b> D. STREET ADDRESS (If rural, give location) <b>5007 ROLAND AVE</b>			
5. SEX <b>F</b>	6. RACE <b>CAUC</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>4-9-15</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Switch Board operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RADIO STATIONS</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James t. MR. LAMB</b>				14. MOTHER'S MAIDEN NAME <b>Mary Bolger</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Robert T. MacLennan 5007 Roland Ave. 10</b>			
18. <b>581.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CIRRHOSIS OF THE LIVER</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ALCOHOLISM</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>66</b> to <b>12/9</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/9</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) view the body after death.							
23A. SIGNATURE <b>Leslie Abramowitz</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-9-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Leslie Abramowitz</b>				23D. ADDRESS <b>SINAI HOSPITAL of BALTIMORE, INC. BELROCK &amp; GREENSPRING AVES</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/12/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorriane Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>			

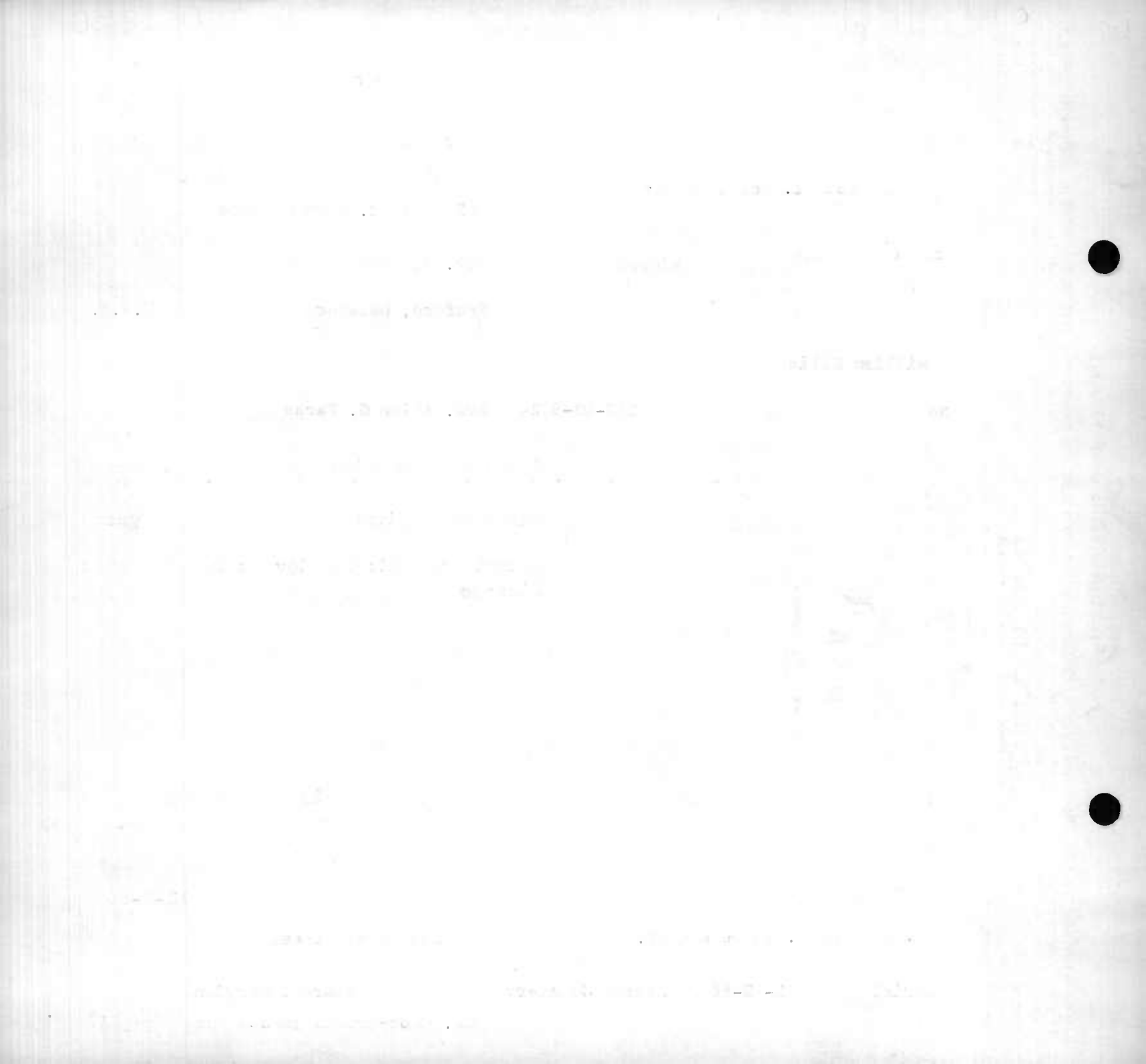




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

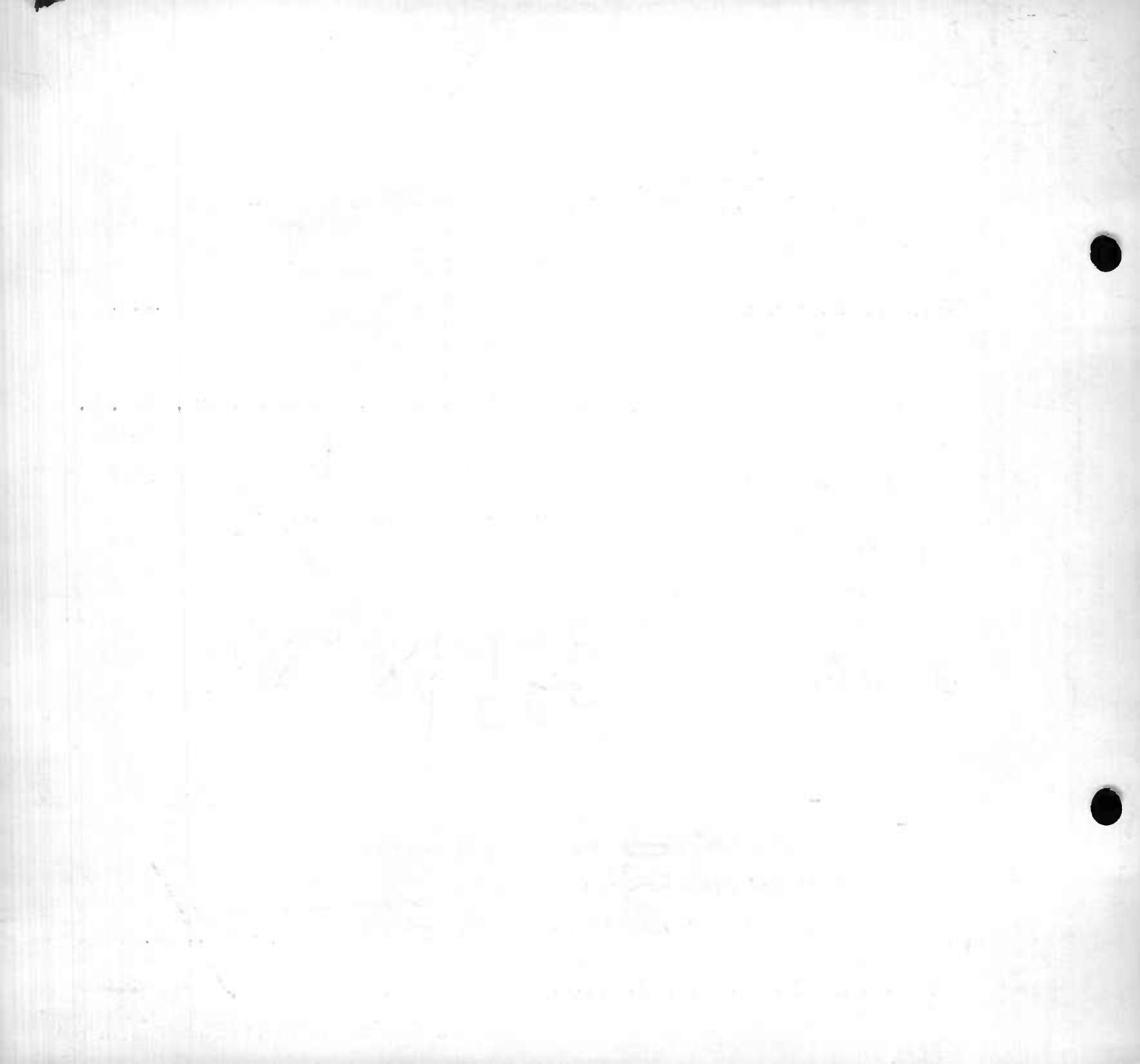
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12456</u>	
BIRTH NO. <u>66 12456</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Alice Gordy</u>		2. DATE AND HOUR OF DEATH <u>December 9, 1966</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>22 East Mt. Vernon Place</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>22 East Mt. Vernon Place</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 9, 1883</u>	9. AGE (in years lost birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Seaford, Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Ellis</u>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-5524</u>		17. INFORMANT <u>Mrs. Alice G. Zaras</u>	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion</u>		<u>1 hour</u>			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<u>15 years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>15 years</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19 63</u> to <u>Present</u> that (I) (we) last saw the deceased alive on <u>December 9</u> <u>19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William H. Townshend Jr.</u>				23B. DATE SIGNED <u>12-9-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. William H. Townshend Jr.</u>		23D. ADDRESS <u>14 East Eager Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-12-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Jessop Cemetery</u>	
24D. LOCATION <u>Sparks, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson Inc</u>			
25D. ADDRESS <u>1050 York Rd. 21204</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

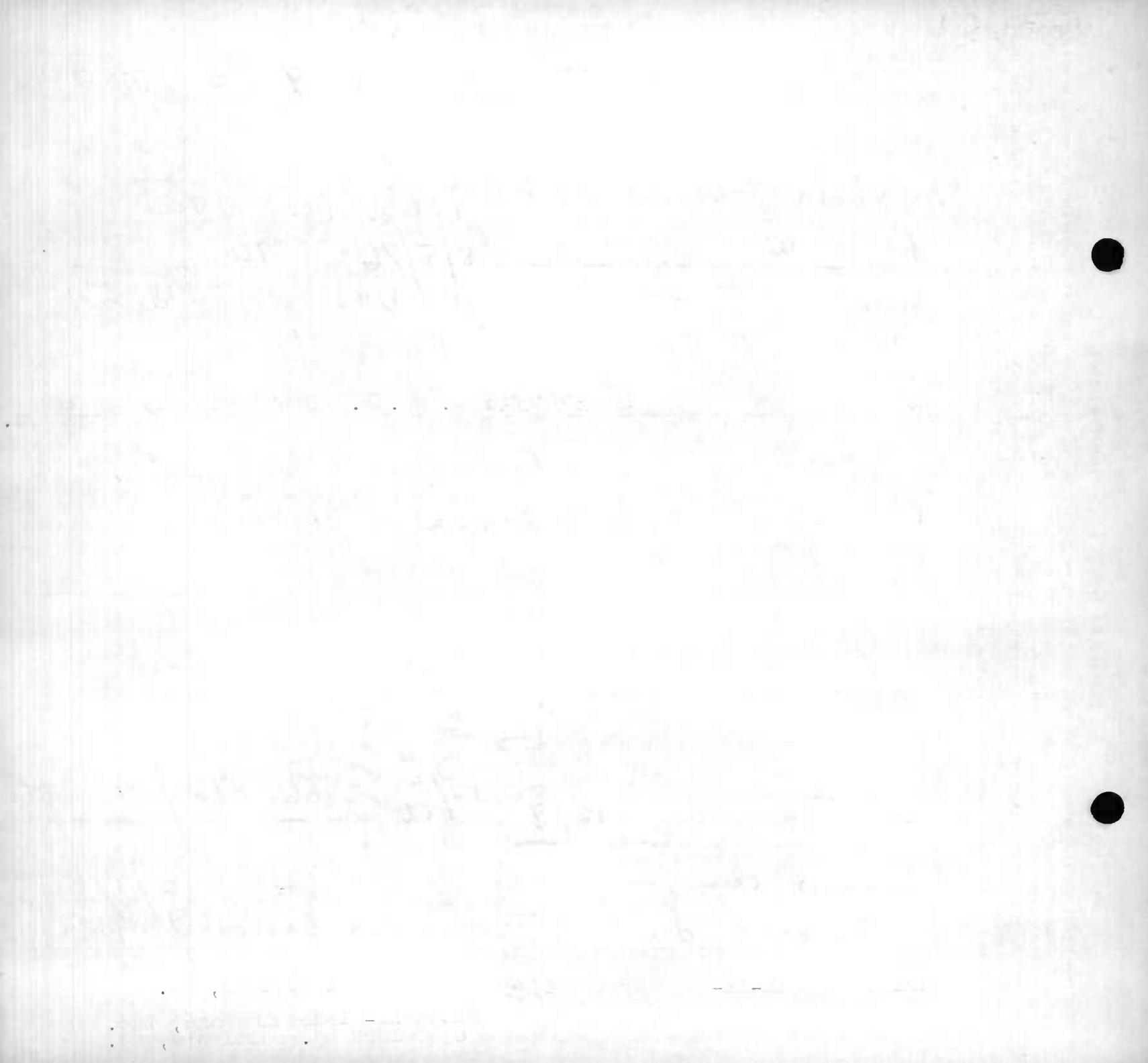
46-69-151 IN 5363		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12457	
BIRTH NO. 66 12457		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Southworth, Charles J.</i>		2. DATE AND HOUR OF DEATH <i>12/12/66 8:30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE Co.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>53-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		D. STREET ADDRESS (If rural, give location) <i>900 OLD OAK ROAD - 21222</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED <i>MARRIED</i>	8. DATE OF BIRTH <i>7/26/03</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PERSONEL DIRECTOR</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>	
13. FATHER'S NAME <i>HARRISON</i>		14. MOTHER'S MAIDEN NAME <i>MOLLIE</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-44-3517</i>		17. INFORMANT ADDRESS <i>RECORDS: BCH, 4940 Eastern Ave, Balto. Md. 21224</i>	
18. <i>420.14-003.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>ANTECEDENT CAUSES</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Hypovolemia</i> DUE TO (B) <i>Possible Myocardial infarct</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Thrombocytopenic Purpura</i>			
19A. DATE OF OPERATION <i>11/30/66</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>T B empyema</i>	20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <i>5/12</i> 19 <i>66</i> to <i>12/12</i> 19 <i>66</i> , that (H) (we) last saw the deceased alive on <i>12/12/</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. A. Alonso MD</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/12/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. A. Alonso MD</i>		23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> <i>4940 Eastern Avenue, Balto., Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>DEC 14, 1966</i>	24C. NAME OF CEMETERY or CREMATORY <i>Washington National Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Suitland, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 13 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson Inc.</i>	
				ADDRESS <i>1050 YORK Rd. Towson, Md</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

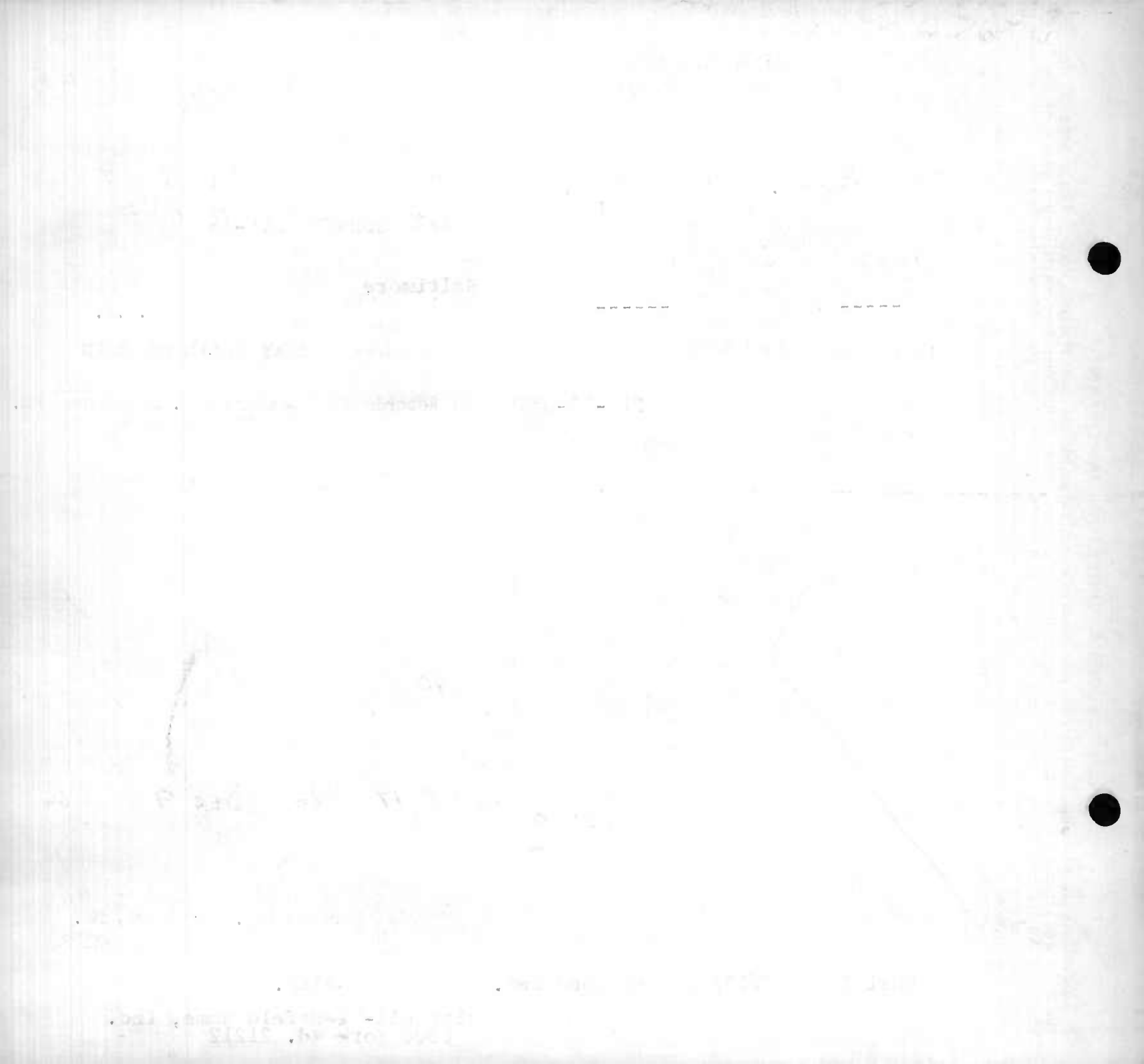
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12458	
CERTIFICATE OF DEATH					
BIRTH NO. 66 12458		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Mary C. Wyatt</i>			2. DATE AND HOUR OF DEATH <i>12/9/66 12:52 P. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>14-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1502 Park Ave.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed.</i>	8. DATE OF BIRTH <i>8/5/76</i>	9. AGE (In years last birthday) <i>90</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Thomas O. Crouse</i>			14. MOTHER'S MAIDEN NAME <i>RAVILLA Russe</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-54-1523</i>	17. INFORMANT <i>Mrs. Wm. A. Blankenship</i> ADDRESS <i>205 Woodlawn Rd.</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Acute Myocardial Infarction with</i> DUE TO (B) <i>Atrial Fibrillation</i> DUE TO (C) <i>u n</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>Dr.</i> (this hospital) attended the deceased from <i>12/5</i> 19 <i>66</i> to <i>12/9</i> 19 <i>66</i> . that <i>Dr.</i> (we) lost saw the deceased alive on <i>12/9</i> 19 <i>66</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>Dr.</i> (We) (did) <i>not</i> view the body after death.					
23A. SIGNATURE <i>Bernard du Buy</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <i>12/9/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Bernard du Buy</i>			23D. ADDRESS <i>Maryland General Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12-12-66</i>	24C. NAME of CEMETERY or CREMATORY <i>Druid Ridge</i>		24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <i>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12459		M.E. CASE NO. 66 12459	
1. NAME OF DECEASED (Type or Print) ELLA MAE BROWN BROWN, ELLA		2. DATE AND HOUR OF DEATH DEC 9 1966 11 <sup>35</sup> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY 4940 Eastern Ave. Baltimore, Maryland 31 HOSPITAL 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY 9-07 D. STREET ADDRESS (If rural, give location) 1732 GORSUCH AVE 18	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 3/31/57 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10B. KIND OF BUSINESS OR INDUSTRY -----	
11. BALTIMORE Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William BROWN		14. MOTHER'S MAIDEN NAME unknown MARY ELLEN MILBURN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-36-0599	
17. INFORMANT		ADDRESS # 21224	
18. 1530 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) ADENOCARCINOMA of Sigmoid Colon	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT 5-17 1966 to DEC 9 1966, that (I) (we) last saw the deceased alive on DEC 9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. E. Wennberg		23B. DATE SIGNED DEC 9, 1966	
23C. PHYSICIAN'S NAME (Type) J. E. WENNBERG		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. BALTIMORE CITY HOSPITAL 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/66	
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		24D. LOCATION Balto.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. 21212	

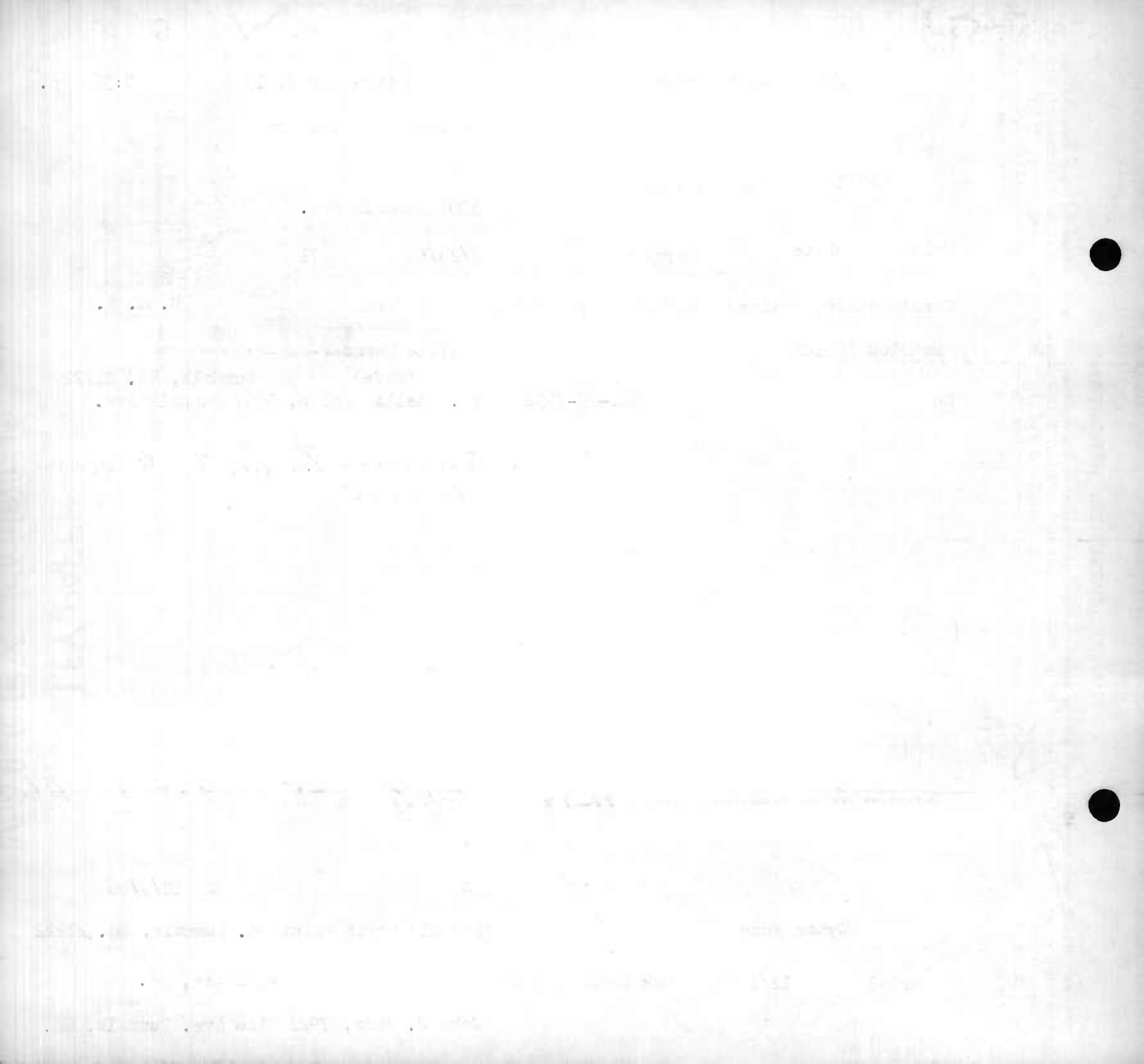




FUNERAL DIRECTOR: IMPORTANT

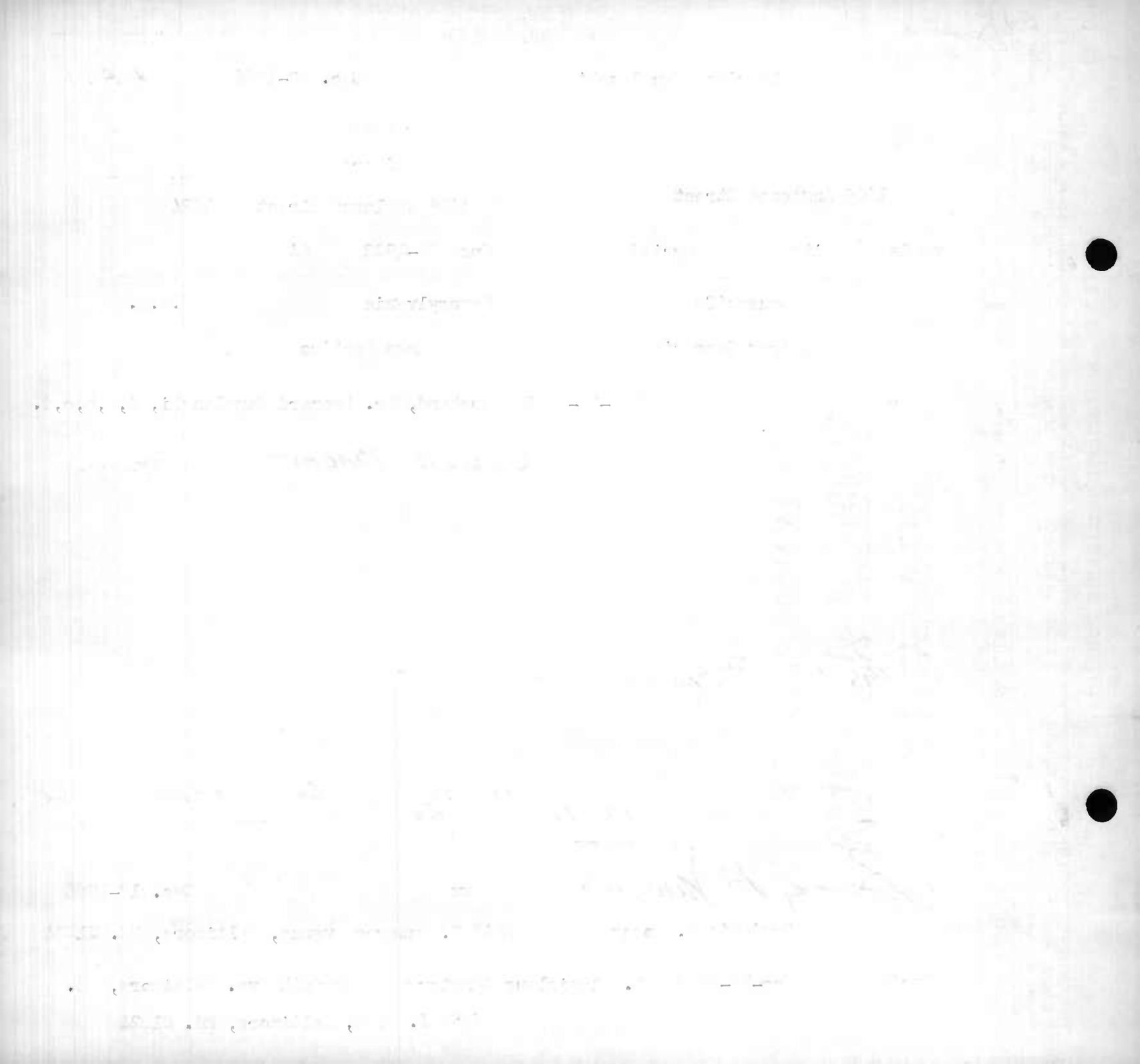
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12460					REGISTERED NO. 66 12460		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>John Joseph Donlon</b>					2. DATE AND HOUR OF DEATH <b>December 7, 1966 4:35 p.m.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>31 Baltimore City Hospital</b>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Dundalk</b>				
					D. STREET ADDRESS (If rural, give location) <b>3007 Dundalk Ave.</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8/28/95</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction, Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Food Fair Properties</b>			11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Patrick Donlon</b>					14. MOTHER'S MAIDEN NAME <b>Nellie Owens</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>101-09-9931</b>		17. INFORMANT (Wife) <b>Dundalk, Md. 21222</b> <b>Mrs. Stella Donlon, 3007 Dundalk Ave.</b>				
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Anterior ischemic heart disease</b>					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO				
					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 1965</b> to <b>12-7 1966</b> , that (I) (we) lost saw the deceased alive on <b>11-18-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE 					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>12/9/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Wyman Wong</b>					23D. ADDRESS M.D. <b>3209 Old North Point Rd. Dundalk, Md. 21222</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/10/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>			25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12461		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12461	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Catherine Szumlanski			2. DATE AND HOUR OF DEATH Dec. 10-1966 4 A.M. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1405 Angleses Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-36 D. STREET ADDRESS (If rural, give location) 1405 Angleses Street 21224		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 28-1922	9. AGE (In years lost birthday) 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Andrew Gossari			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Rose Nestico			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 198-16-9032		17. INFORMANT ADDRESS Husband, Mr. Leonard Szumlanski, 4,a,b,c,d.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 170 X I CANCER - BREAST			INTERVAL BETWEEN ONSET AND DEATH 99 years		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1957		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER - Breast		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-7-1966 to 12-10-1966, that (I) <del>was</del> lost saw the deceased alive on 12-10-1966 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did</del> (did not) view the body after death.					
23A. SIGNATURE Benjamin B. Moses, M.D.				23B. DATE SIGNED Dec. 12-1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. 448 N. Luzerne Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec-13-1966		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Dundalk Ave. Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1966			
25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, Baltimore, Md. 21224			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 12462		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.		66 12462	
1. NAME OF DECEASED (Type or Print) <b>WILBERT L. LAWSON</b>						2. DATE AND HOUR OF DEATH <b>12-9-66</b>   <b>12<sup>35</sup></b> P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore C.</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE - Dundalk</b> <b>53-00</b>					
D. STREET ADDRESS (If rural, give location) <b>7922 KAVANAUGH ROAD</b> <b>21222</b>											
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>		8. DATE OF BIRTH <b>10-11-05</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL WORKER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>BETHLEHEM STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>EDWARD LAWSON</b>						14. MOTHER'S MAIDEN NAME <b>MARIE SKINNER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-10-5053</b>		17. INFORMANT <b>Mrs. Doris Franzoni, # 4,a,b,c,d.</b>				ADDRESS	
18. <b>141.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Carcinoma tongue</b> <b>meta stas</b> (B) <b>due to</b> (C) <b>due to</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>12/13/66</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/21</b> 19 <b>66</b> to <b>12/9</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/9</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Nicholas C. Bosch</b> M.D.						23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type) <b>Nicholas C. Bosch</b>						23D. ADDRESS <b>Maryland General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12-13-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Holly Memorial Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Charlottesville, Virginia</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1966</b>				25B. NAME OF REGISTRAR <b>John E. ...</b>				25C. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>			

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NOT A MEDICAL EXAMINER'S CASE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12463		BALTIMORE CITY HEALTH DEPARTMENT FOR THE PERSONAL USE OF THE PHYSICIAN NOT FOR HOSPITAL CHARGE		Registered No. 66 12463	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIE WILLIAMS		2. DATE AND HOUR OF DEATH 12-6-66 4:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. SEX MALE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33 BALTIMORE, MD 21205		Office of the Chief Medical Examiner MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 828 N. BOND STREET		6. RACE NEGRO	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 7-12-94		9. AGE (in years last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Littleton, N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN HENRY WILLIAMS		14. MOTHER'S MAIDEN NAME BETTY FAULKNER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 145-10-5548		17. INFORMANT Mrs Rosa Jenkins 828 N. Bond St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., but the disease, injury or complication which caused death) RESPIRATORY ARREST 5 MIN		19. CAUSE OF DEATH (A) DUE TO ACUTE RENAL FAILURE 7 days		INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS if any, giving rise to the above cause (A) state the underlying condition SERUM HEPATITIS 3 weeks		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CLOSING IT. Multiple GU URETHRAL STRICTURES			
22. I certify that (I) (this hospital) attended the deceased from 12/1 1966 to 12/6/66 1966, that (I) (we) last saw the deceased alive on 12/6/66 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE S. Mishkin		23B. DATE SIGNED 12/6/66	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Ralph E. Collier	
25C. FUNERAL DIRECTOR Ralph E. Collier		25D. ADDRESS 2431 E. Oliver St.			





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12464</u>	
BIRTH NO. <u>66 12464</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Audrey M. Saunders</u>		2. DATE AND HOUR OF DEATH <u>12-11-66</u>   <u>10:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>909 Evesham Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>8-13-18</u>	9. AGE (In years last birthday) <u>48</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Meyers</u>		14. MOTHER'S MAIDEN NAME <u>May Kiel</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-7642</u>		17. INFORMANT <u>Mr James Saunders</u>	
				ADDRESS <u>Same</u>	
18. <u>416X I</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Rheumatic Heart Disease</u> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Disease</u> DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>11-9-1966</u> to <u>12-11-1966</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12-11-1966</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mirion R. Cohen</u> - M.D.				23B. DATE SIGNED <u>12-11-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MIRION R COHEN</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/14/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Lake View Memorial Park</u>	
				24D. LOCATION (City, town, or county) (State) <u>Randlestown, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Seitz</u>		25C. FUNERAL DIRECTOR <u>Eugenia R. Seitz</u>	
				ADDRESS <u>5209 York Rd. Balto. Md. 21212</u>	

Charles Taylor

Long Mountain

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May Kiel

Harvard

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Mr. James Taylor

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Wm. R. Taylor

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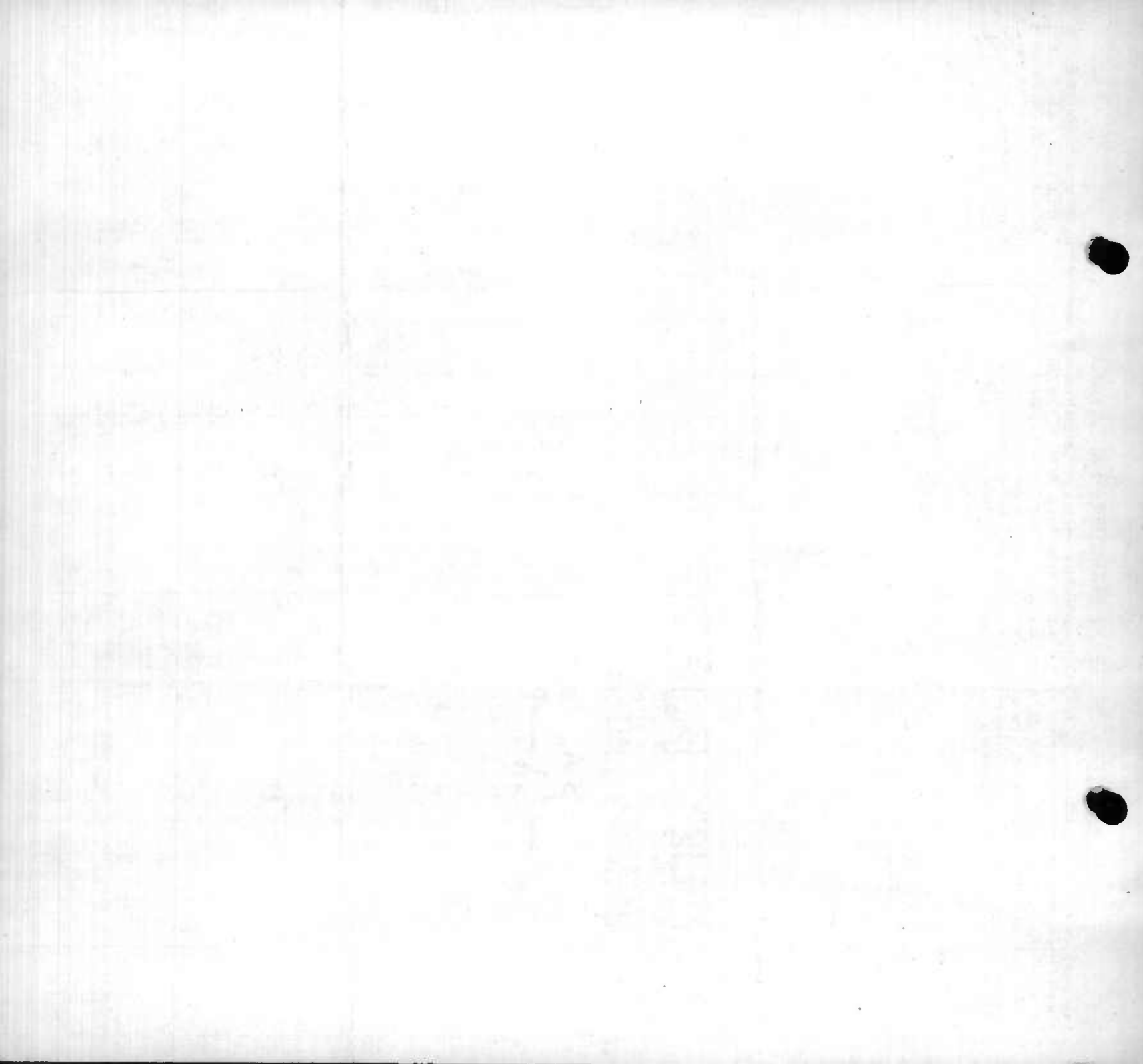
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12465		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12465	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JAMES P. GILBRIDE		2. DATE AND HOUR OF DEATH 12-12-66 10:35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		A. STATE Maryland B. COUNTY Balto. Co.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00			
		D. STREET ADDRESS (If rural, give location) 5605 Braxfield Rd.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-15-99	9. AGE (In years last birthday) 67	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Board of Education		11. BIRTHPLACE (State or foreign country) Penn	
13. FATHER'S NAME Michael Gilbride		14. MOTHER'S MAIDEN NAME Mary Ellen Gallagher		12. CITIZEN OF WHAT COUNTRY? U.S.P.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 206-107022		17. INFORMANT ADDRESS Lutheran Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Carcinoma of stomach. DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-21-1966 to 12-12-1966 that (I) (we) last saw the deceased alive on 12-12-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucas C. Vidnyaphum M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) LUCAS C. VIDNYAPHUM M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/66		24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery	
24D. LOCATION (City, town, or county) State) Lancaster, Penn		25A. DATE REC'D BY HEALTH DEPT DEC 14 1966		25B. NAME OF REGISTRAR Robert E. J. M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS 1328 Dupont St. Ed.			



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66 12466  
BIRTH NO. 65-23114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12466

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		ROLAND SPRIGGS		2. DATE AND HOUR PRONOUNCED DEAD December 3, 1966 3:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital (DOA)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bristol 52-00 D. STREET ADDRESS (If rural, give location) Bristol P.O.	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 9-5-1965	9. AGE (In years last birthday) 1	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Melvin Spriggs			14. MOTHER'S MAIDEN NAME Carrie Burley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No **		16. SOCIAL SECURITY NO. None	17. INFORMANT Josephine A. Burley Bristol, Md		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral pneumonia with fibrinopurulent pleuritis and pericarditis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 4, 1966	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 12-10-66		23C. NAME OF CEMETERY or CREMATORY Moses	
23D. LOCATION (City, town, or county) (State) Bristol A.A. Co Md		24A. DATE REC'D BY HEALTH DEPT. DEC 14 1966		24B. NAME OF REGISTRAR Robert E. Fisher	
24C. FUNERAL DIRECTOR C.E. Hicks, 111		24D. ADDRESS Annapolis, Md			

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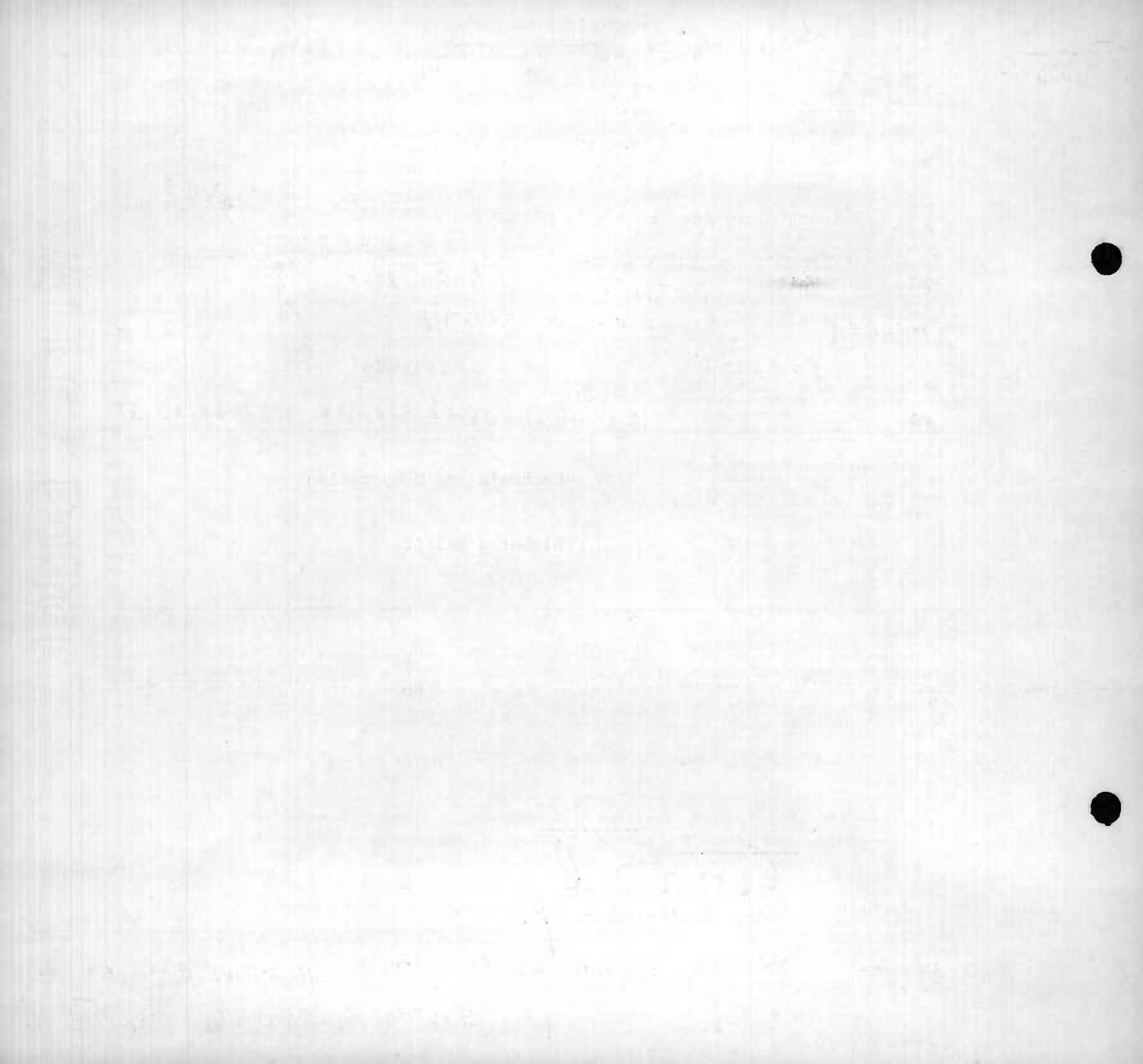
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 12467

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>MELVIN SEEMAN</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>December 4, 1966 4:40 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 8 South Carey Street</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 19-03</b> D. STREET ADDRESS (If rural, give location) <b>8 South Carey Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-20-1906</b>	9. AGE (in years last birthday) <b>60</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HELPER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LABELING CO</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>SEEMAN</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-14-3215</b>		17. INFORMANT ADDRESS <b>EVA L. SEEMAN 1400 HOLLINS ST</b>	
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
					(A) DUE TO <b>Cachexia and Dehydration</b>
					(B) DUE TO <b>Diabetes Mellitus</b>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/5/66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23B. DATE <b>12-13-66</b>		23C. NAME OF CEMETERY or CREMATORY <b>GLENHAVEN CEMETERY</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1966</b>		24B. NAME OF REGISTRAR <b>P. J. E. Tolson</b>		24C. FUNERAL DIRECTOR ADDRESS <b>WALTERS FUNERAL HOME PRATT + STRICKER STS.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12468		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12468	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JENKINS, K. MARGARET		2. DATE AND HOUR OF DEATH 12-12-66 9:15A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE 32-00 D. STREET ADDRESS (If rural, give location) 7823 BALTIMORE & ANNAPOLIS BLVD.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-3-96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? LITHUANIA		13. FATHER'S NAME JOSEPH LENKUNE		14. MOTHER'S MAIDEN NAME PAT Lenkuite	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217017655		17. INFORMANT ST. AGNES RECORDS-CATON & WILKENS AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 386X I CAUSE OF DEATH Cerebral anoxia - 13 hrs. Cardiac arrest - 13 hrs. Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Obstructive jaundice 2 wks.		INTERVAL BETWEEN ONSET AND DEATH 12/29/66			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. choledochal lithiasis - Renal failure, hydrops gall bladder					
19A. DATE OF OPERATION 12-9-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive jaundice		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 23 19 66 to DECEMBER 12 19 66, that (I) (yes) last saw the deceased alive on DECEMBER 12 19 66 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (yes) (did) (did not) view the body after death.					
23A. SIGNATURE A. GARRISON		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Dec 12-1966	
23C. PHYSICIAN'S NAME (Type) A. GARRISON		23D. ADDRESS M.D. 3350 WILKENS AVES. BALTO, MD. 21229			
24A. BURIAL CREMATION, REMOVAL Burial		24B. DATE 12/15/66		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cam.	
24D. LOCATION Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1966		25B. NAME OF REGISTRAR R. E. Johnson		25C. FUNERAL DIRECTOR John J. Brown & Sons Inc. 901 Hollins St. 23, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12469</span>	
BIRTH NO. <span style="float: right;">66 12469</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="float: right;">Milbern J. Tacy</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">12/11/66 8<sup>00</sup> A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">48 Maryland General Hospital</span>		A. STATE <span style="float: right;">Md.</span> B. COUNTY <span style="float: right;">BALTIMORE CO.</span>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">BALTO #21222 53-00</span>			
		D. STREET ADDRESS (If rural, give location) <span style="float: right;">1881 Marshall Rd.</span>			
5. SEX <span style="float: right;">MALE</span>	6. RACE <span style="float: right;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="float: right;">MARRIED</span>	8. DATE OF BIRTH <span style="float: right;">3/30/00</span>	9. AGE (In years last birthday) <span style="float: right;">66</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">PNEUMOLOGIST</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">LABORER</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">HUTTENSVILLE, W. VA.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>		13. FATHER'S NAME <span style="float: right;">Jacob J. Tacy</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Florence Gibson</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) <span style="float: right;">NO</span>		16. SOCIAL SECURITY NO. <span style="float: right;">236-12-4159</span>		17. INFORMANT <span style="float: right;">HATTIE M. TACY</span> ADDRESS <span style="float: right;">1881 MARSHALL RD. BALTO. 21222, MD.</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <span style="float: right;">420.01</span>		CAUSE OF DEATH <span style="float: right;">ARTERIOSCLEROTIC HEART DISEASE</span>			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <span style="float: right;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">9/21</span> 19 <span style="float: right;">66</span> to <span style="float: right;">12/11</span> 19 <span style="float: right;">66</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">12/11</span> 19 <span style="float: right;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">Daniel C. Wilkerson</span> M.D.				23B. DATE SIGNED <span style="float: right;">12/11/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">Daniel C. Wilkerson</span> M.D.				23D. ADDRESS <span style="float: right;">421 Regester Ave.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">BURIAL</span>		24B. DATE <span style="float: right;">12-14-66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">TACY HOME CEM.</span>	
24D. LOCATION (City, town, or county) (State) <span style="float: right;">HUTTENSVILLE, W. VA.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">DEC 14 1966</span>		25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Taylor</span>	
25C. FUNERAL DIRECTOR <span style="float: right;">Charles S. Zeiler</span>		25D. ADDRESS <span style="float: right;">901 S. CONKLING ST. BALTO. 21224, MD.</span>			

For your kind reply  
I am very  
sincerely  
yours  
J. H. [unclear]

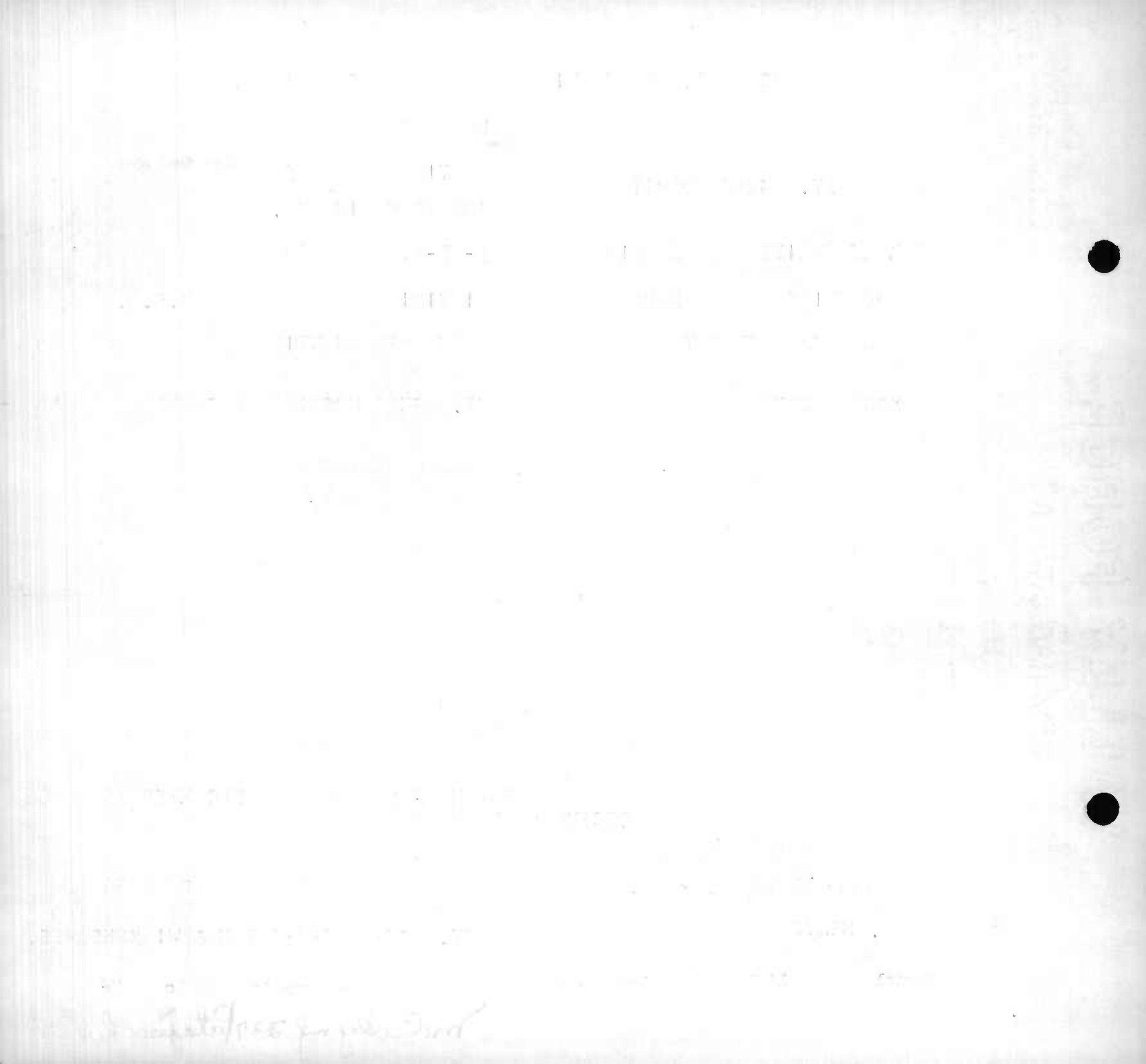
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12470</u>	
BIRTH NO. <u>66 12470</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>SCHOOLS, EVELYN MILDRED</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 12, 1966</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>J. G. Co.</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 21225</u>			
		D. STREET ADDRESS (If rural, give location) <u>104 FRANKLIN AVE.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>MARRIED</u> WIDOWED DIVORCED (specify)	8. DATE OF BIRTH <u>3-13-17</u>	9. AGE (In years lost birthday) <u>49</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>HENRY GREENSTREET</u>			14. MOTHER'S MAIDEN NAME <u>ANNA BELL MARTIN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE NONE</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>ST. AGNES HOSPITAL RECORDS</u>	
18. <u>170X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic carcinoma of Q Breast, widespread.</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 29</u> 19 <u>66</u> to <u>DECEMBER 12</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 12</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John B. Bert...</u>				23B. DATE SIGNED <u>12/12/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. HERTS</u>				23D. ADDRESS <u>21229 ST. AGNES HOSP; CATON &amp; WILKENS AVES.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/15/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven</u>	
24D. LOCATION <u>Glen Burnie AA Co Md</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>DEC 14 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>McCully, 237 Patapsco Ave #25</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12471	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 66 12471</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>Anna E. Lynch</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>12-10-1966 6 pm -</b></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Ashburton House Inc 3520 Hilton Rd Balto 15 Md</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balt Co 53.00</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>3015 Lavender Avenue 21231</b></p>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>9/1/1887</b>	9. AGE (In years lost birthday) <b>79</b>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>School Cafeteria</b>		11. BIRTHPLACE (State or foreign country) <b>Balt Co</b>
13. FATHER'S NAME <b>John F. Itzell</b>			14. MOTHER'S MAIDEN NAME <b>Lydia Krank-</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-1289-85</b>		17. INFORMANT <b>Miss Evelyn Lynch 3015 Lavender Avenue</b>
18. <b>420.0 I</b>			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) <b>Arteriosclerotic heart disease</b>		<b>9 mo +</b>
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(B) DUE TO		
ANTECEDENT CAUSES			(C) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White A <input type="checkbox"/> Not White A <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>3-26-66</b> 19 <b>66</b> to <b>12-10</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/10</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert A. Reiter</b>				23B. DATE SIGNED <b>12/10/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert A. Reiter</b>				23D. ADDRESS <b>606 Edmondson Ave. Balto 28</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-12-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Balt Co Md.</b>		24E. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		24F. ADDRESS <b>Taylor Ave Balto Co</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltner</b>		25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 12472</b>	
BIRTH NO. <b>66 12472</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Elsie Watts</b>		2. DATE AND HOUR OF DEATH <b>December 11, 1966 4:15a M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland 21217</b>		C. CITY OR TOWN (If outside city limits, write RURA and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1913 Druid Hill Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5-1-00</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		13. FATHER'S NAME <b>Cram Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Owens</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214387359</b>		17. INFORMANT <b>Kenneth Watts</b> ADDRESS <b>1913 Druid Hill Avenue</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>II</b> <b>Ante Cholecystitis &amp; Cholelithiasis</b>		19. DATE OF OPERATION <b>2</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 15, 1966</b> to <b>December 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 12, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Myrtle James</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>December 12, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Javier</b>		23D. ADDRESS M.D. <b>1514 Division Street-Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-16-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>George G. Kelson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1348 N. Calhoun St.</b>			

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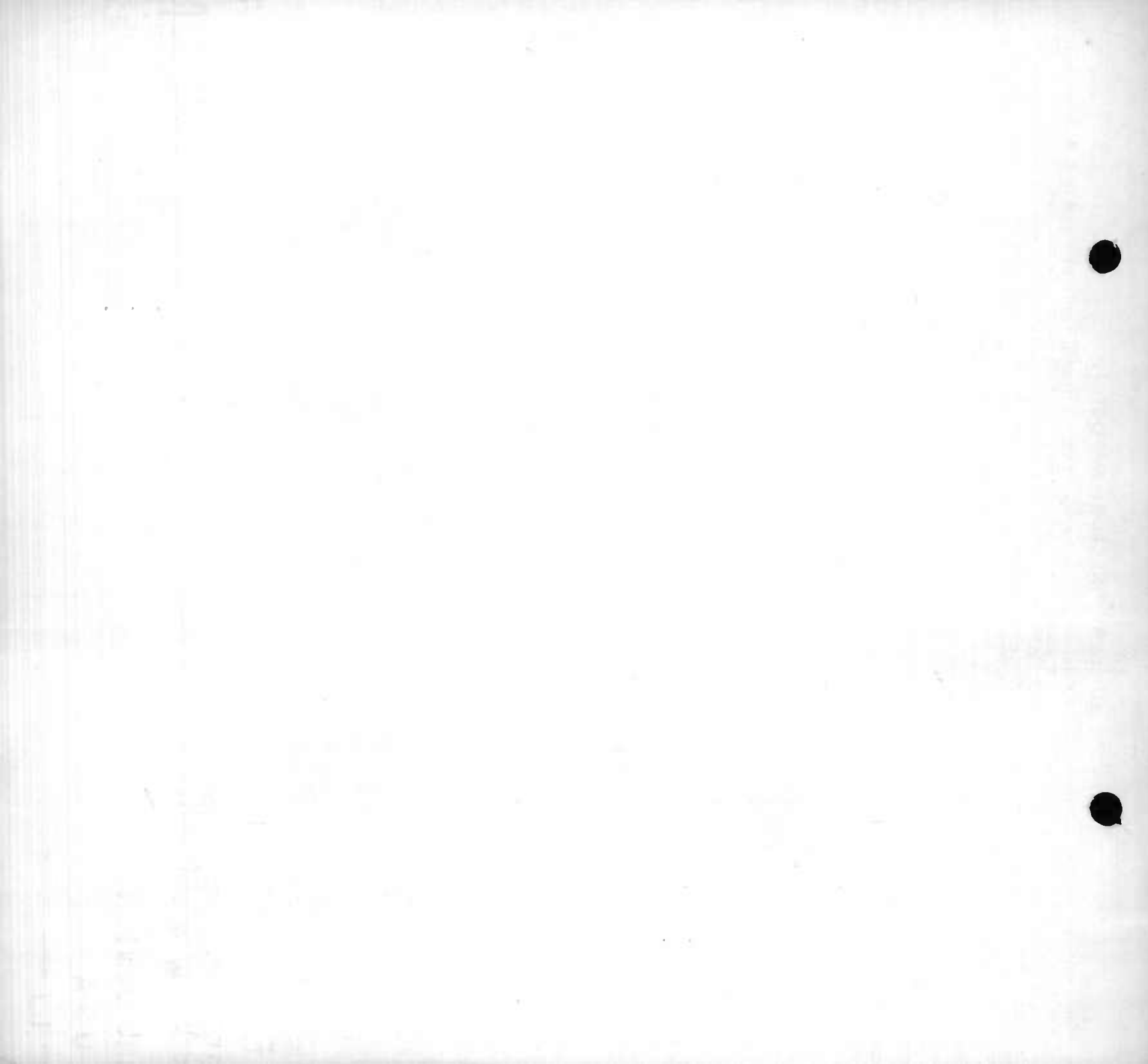
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12473					CERTIFICATE OF DEATH			Registered No. 66 12473	
1. NAME OF DECEASED (Type or Print) <b>Smith, Norman A.</b>					2. DATE AND HOUR OF DEATH <b>12-11-66 5<sup>20</sup> A M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2915 BAKER STREET 21216</b>				
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>11-13-00</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES SMITH</b>					14. MOTHER'S MAIDEN NAME <b>FLORENCE TITTLE</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>219308105</b>		17. INFORMANT ADDRESS <b>Dorothy Smith 2915 Baker Street</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>? Hepatoma</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Indeterminate</b> <b>Indeterminate</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>12-9-66</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Liver Biopsy</b>			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Dec. 3</b> 19 <b>66</b> to <b>Dec 11</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec. 11</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>A.P. Weinfeld</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>Dec 11, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>A.P. WEINFELD</b>					23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-15-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>			24D. LOCATION (City, town, or county) (State) <b>Arbutus Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1966</b>			25B. NAME OF REGISTRAR <b>George Kelson</b>			25C. FUNERAL DIRECTOR ADDRESS <b>1348 CALHOUN ST.</b>			



B-164

66 12474

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 12474

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SHIRLEY N. BEVERLY

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1966

11:50 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

727 Harford Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

9-17-1900

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

Gas &amp; Electric Co.

11. BIRTHPLACE (State or foreign country)

King Williams Co., Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Nathan Beverly

14. MOTHER'S MAIDEN NAME

Mildred

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Nat Beverly - 200 N. Aisquith St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Hypertensive and arteriosclerotic  
cardiovascular disease(A) \_\_\_\_\_  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 9, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-14-66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.

WALLACE'S PRINCIPLE

PS/AND CONT

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12475	
BIRTH NO. 66 12475		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Hall, Gertrude M.</i>		2. DATE AND HOUR OF DEATH <i>12/11/66 10:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i> <i>48</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>3407 Dolfield Ave</i>	
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9/27/92</i>	9. AGE (In years last birthday) <i>74</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph Tucker</i>		14. MOTHER'S MAIDEN NAME <i>AMANDA ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>217 015918</i>		17. INFORMANT ADDRESS <i>Lillian H. Bell - 3407 Dolfield Ave.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebrovascular Accident 19 days</i>		CAUSE OF DEATH (A) DUE TO <i>Hypertensive Arterioscler. C.V. Disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from <i>11/22</i> 19 <i>66</i> to <i>12/11</i> 19 <i>66</i> and that (we) lost saw the deceased alive on <i>12/11</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Bernard du Buy</i>		23B. DATE SIGNED <i>12/11/66</i>		23C. PHYSICIAN'S NAME (Type) <i>Bernard du Buy</i> M.D.	
23D. ADDRESS <i>Maryland General Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-15-66</i>	
24C. NAME of CEMETERY or CREMATORY <i>St. Joseph Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Texas, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles R. Law 802 Madison Ave.</i>	

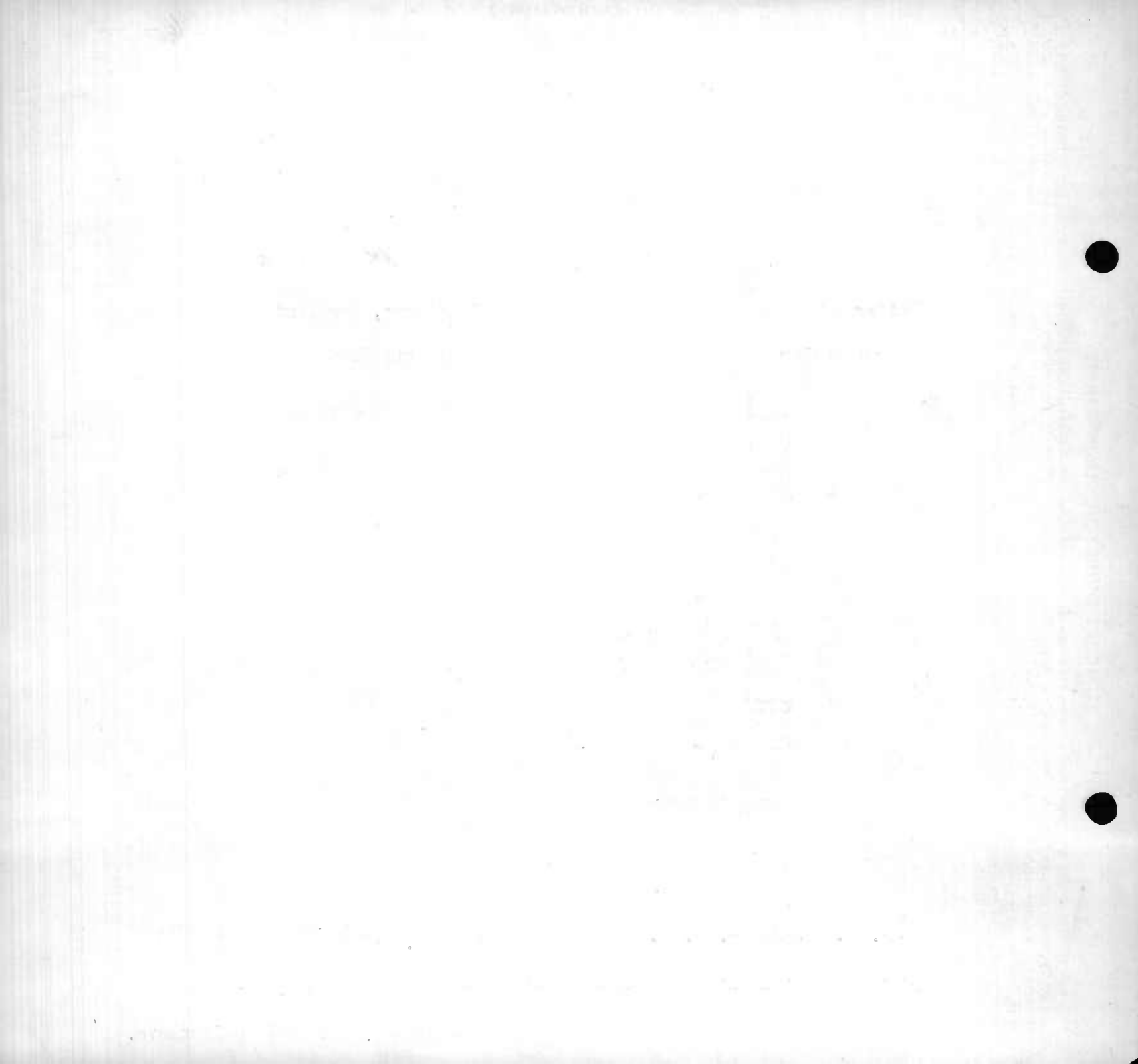




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>66 12476</u>
BIRTH NO. <u>66 12476</u>						CERTIFICATE OF DEATH
M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) <u>George R. Butler</u>				2. DATE AND HOUR OF DEATH <u>12-8-66</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Dukeland Nursing &amp; Convalescent Home</u> <u>90</u>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>13-01</u>		
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>9-29-88</u>		
13. FATHER'S NAME <u>George Butler</u>		14. MOTHER'S MAIDEN NAME <u>Alverta Ines</u>		9. AGE (In years last birthday) <u>78</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		
17. INFORMANT <u>MARJORIE L. Butler (Wife)</u>		ADDRESS <u>SAME</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
18. <u>722 / I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO <u>Parkinsonism</u> DUE TO <u>Antecedent causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.				INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Dr. P. Smith / Dr. T. W. Harris</u> M.D.				23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>Dr. P. Smith / Dr. T. W. Harris</u> M.D.				23D. ADDRESS <u>Dukeland Nursing &amp; Convalescent Home</u> <u>1501 N. Dukeland Street</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-13-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Carver Memorial Park</u>		
24D. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1966</u>		25B. NAME OF REGISTRAR <u>Charles R. Law</u>		
25C. FUNERAL DIRECTOR <u>Charles R. Law</u>		25D. ADDRESS <u>802 Madison Ave.</u>				



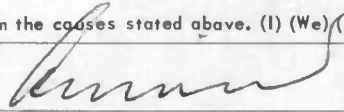
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12477		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12477	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Charles Henry Shadle, Sr.		2. DATE AND HOUR OF DEATH Dec. 13, 1966 4 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		21-02	
US Public Health Service Hospital Wyman Pk. Drive & 31st Street		D. STREET ADDRESS (If rural, give location) 1121 Sargent Street			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/6/04	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SFC retired		10B. KIND OF BUSINESS OR INDUSTRY Serviceman		11. BIRTHPLACE (State or foreign country) Ill.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles W. Shadle		14. MOTHER'S MAIDEN NAME Norma Ritzman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, 22-23 or 29-33 service) Yes USA & 41-60		16. SOCIAL SECURITY NO. 218-05-3586		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.11-163X Ventricular fibrillation (A) DUE TO		CAUSE OF DEATH Ventricular fibrillation		INTERVAL BETWEEN ONSET AND DEATH Terminal	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Myocardial infarction		Terminal	
		(C) Coronary artery disease		3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Carcinoma of left lung Respiratory distress with cyanosis		1 year 6 hours	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Oct. 13 19 66 to Dec. 13 19 66, that (I) (we) last saw the deceased alive on Dec. 13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Allen B. Bredt		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/13/66	
23C. PHYSICIAN'S NAME (Type) Allen B. Bredt, Surgeon (R)		M.D. 23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/66		24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 14 1966		25B. NAME OF REGISTRAR John J. Cowanston Jr.	
25C. FUNERAL DIRECTOR John J. Cowanston Jr.		ADDRESS 901 St. Holling		937 Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12478</u>	
BIRTH NO. <u>66 12478</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>Ann Williams (Ary Annie Thompson)</u>		<u>December 12, 1966</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>39</u> Provident Hospital 1514 Division Street Baltimore, Maryland 21217		A. STATE <u>Maryland</u>			
		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>822 N. Carrollton Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>10-27-79</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Boring Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Henry Thompson</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Ann Meyers</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT ADDRESS <u>Mrs. E. Cornelia Gregory 1415 N. Longwood St.</u>		
18. <u>490X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Bilateral bronchopneumonia</u> DUE TO (B) <u>Pulmonary edema, right lung</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 9, 1966</u> to <u>December 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>December 11, 1966</u> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <u>December 12, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Amini</u>		23D. ADDRESS <u>1514 Division Street - Baltimore, Maryland</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12-15-66</u>	24C. NAME OF CEMETERY or CREMATORY <u>St. Luke's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Hereford, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1966</u>		25B. NAME OF REGISTRAR <u>Dr. E. E. Feltner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Marshall W. Jones, Jr. 1735 Harford Ave.</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12479		CERTIFICATE OF DEATH				Registered No. 66 12479			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lewis, Justice (John)</i>				2. DATE AND HOUR OF DEATH <i>12-11-66 @ 8:05 AM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
5. SEX <i>M</i>		6. RACE <i>C</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Divorced</i>		8. DATE OF BIRTH <i>10-31-88</i>		9. AGE (In years, last birthday) <i>78</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Medicare</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (state or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William Lewis</i>						14. MOTHER'S MAIDEN NAME <i>Hannah Billinsley</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>219-01-8760</i>		17. INFORMANT ADDRESS <i>Mr. Lee F. Lewis 711 E. 20th St. 21218</i>					
18. <i>420.11</i>		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Uremia, ? M.I.</i>		(B) DUE TO		(C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>12/10</i> 19 <i>66</i> to <i>12/11</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/11</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>W. S. Wilson</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/11/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. S. Wilson</i>				23D. ADDRESS <i>JHH</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-14-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbustus Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1966</i>		25B. NAME OF REGISTRAR <i>P. J. E. Jones</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Marshall W. Jones, Jr. 1735 Harford Ave.</i>					

52

10-10-10

10-10-10

10-10-10

10-10-10



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12480	
BIRTH NO. 66 12480		CERTIFICATE OF DEATH		Registered No. 66 12480	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>William Joseph Ozaewski</i>		2. DATE AND HOUR OF DEATH <i>12-12-66 12/40 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>BALTO. CITY</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>406-S-CASTLE ST.</i>		D. STREET ADDRESS (If rural, give location) <i>406-S-CASTLE ST.</i>			
5. SEX <i>MALE</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>1-27-1899</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TAILORING</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>TAILOR</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO. MD.</i>	
13. FATHER'S NAME <i>Mathew</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Majeewski</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-09-0535</i>		17. INFORMANT ADDRESS <i>ELNOR-OZAEWSKI</i>	
18. <i>157X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <i>Carcinoma of Pancreas</i>		1 Yr.	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>NO</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>July 8</i> 19 <i>66</i> to <i>Dec. 12</i> 19 <i>66</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Dec. 6</i> 19 <i>66</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Clarence W. LeDoux</i> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/14/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Clarence W. LeDoux</i> M.D.		23D. ADDRESS <i>3025 Eastern Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>12-15-66</i>	24C. NAME OF CEMETERY or CREMATORY <i>GARDEN OF FAITH</i>	24D. LOCATION (City, town, or county) (State) <i>Towpns Mill Rd. BA. Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1966</i>	25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	25C. FUNERAL DIRECTOR ADDRESS <i>Geo. C. Fisher 1930 Eastern Ave.</i>			

Mr. J. C. Galt  
1010 1st Street  
St. Louis, Mo.  
Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named matter. I have the same referred to the proper authorities for their consideration. I will endeavor to have the same decided as soon as possible and will advise you of the result.

Very respectfully,  
J. C. Galt

## CERTIFICATE OF DEATH

Registered No.

66 12481

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Higdon, Ralph

2. DATE AND HOUR OF DEATH

12-10-66

1:30 a.m.

3. PLACE OF DEATH OF BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Ave - Baltimore, Md 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4940 EASTERN AVENUE, BALTIMORE, MD.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
DIVORCED

8. DATE OF BIRTH

6-7-01

9. AGE (In years  
last birthday)

65

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Farmer (retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Higdon

14. MOTHER'S MAIDEN NAME

Clara Nonback

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 EASTERN AVENUE, 21224

18. 008,111

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

TUBERCULOSIS

Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1 Dec 1966 to 10 Dec 1966,  
that (I) (we) last saw the deceased alive on 9 Dec 1966 and that in (my) (our) opinion death occurred on the date.

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10 Dec 66

23C. PHYSICIAN'S  
NAME (Type)

Dr. Joseph Berman

M.D.

23D. ADDRESS

BCH-4940 EASTERN AVENUE-BALTIMORE, MD

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/13/66

24C. NAME OF CEMETERY or CREMATORY

Knoxville Cemetery

24D. LOCATION

Knoxville

(City, town, or county)

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

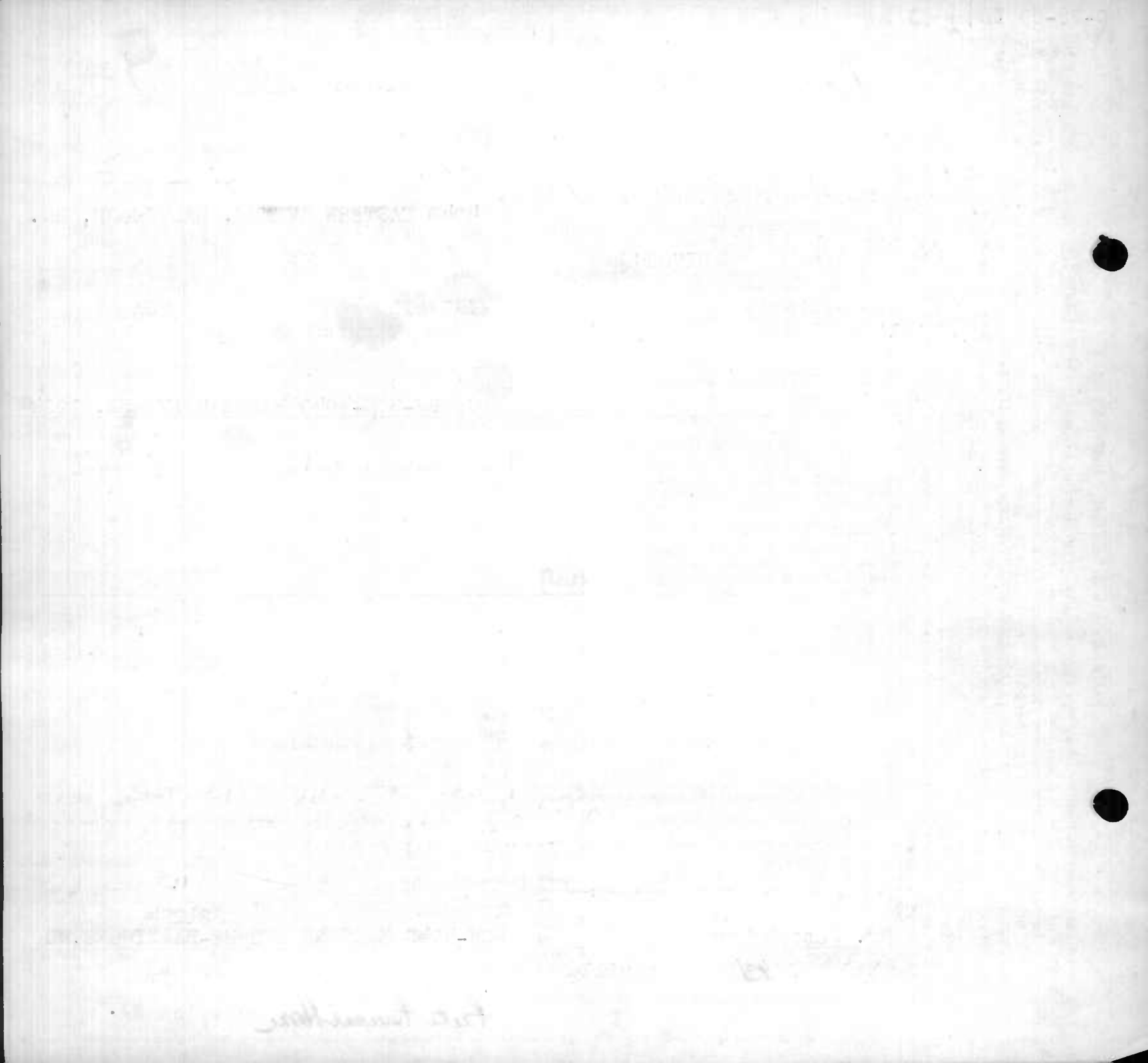
25C. FUNERAL DIRECTOR

Brunswick Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1  
M-635

66 12482

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 12482

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

VERLETTA MARTIN

2. DATE AND HOUR PRONOUNCED DEAD

12-11-66

11:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

516 Garrett Street 21225

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Nov 18, 1897

9. AGE (In years  
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Washington Pumphrey

14. MOTHER'S MAIDEN NAME

Hannah Griffith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple injuries  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Patapsco and 5th Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
12 11 '66 PM

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-12-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/15/66

23C. NAME of CEMETERY or CREMATORY

Ceadr Hill

23D. LOCATION

AA Co.

(City, town, or county)

Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

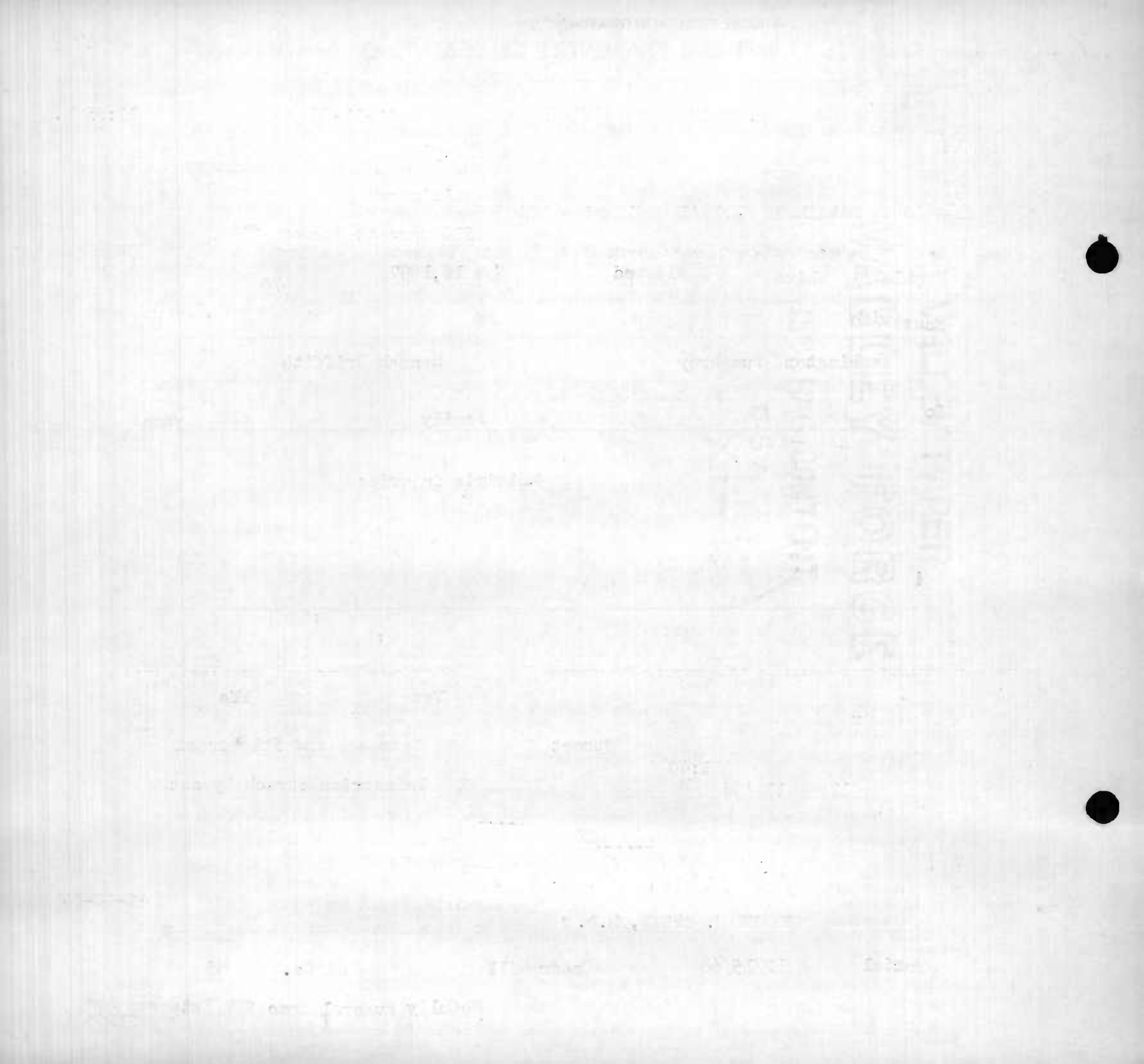
24C. FUNERAL DIRECTOR

ADDRESS

DEC 14 1966

Robert E. Taylor, M.D.

McCully Funeral Home 237 Patapsco Ave  
21225



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM T. RINN

2. DATE AND HOUR PRONOUNCED DEAD

December 10, 1966 6:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Balt. Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

RURAL Randallstown

D. STREET ADDRESS (If rural, give location)

3605 Belair Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11/21/1906

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore City

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

John Rinn

14. MOTHER'S MAIDEN NAME

Mary Moran

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

219-18-5136

17. INFORMANT

Mrs. Julia J. Rinn-3605 ~~Belair~~ Ave. Rand.

ADDRESS

Blair

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

300 Block of W. Fairmount Ave.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour) (Min)  
12 9 '66 10:40

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently was Assaulted

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/14/66

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

(City, town, or county)

(State)

4300 Old Frederick Rd. Balt

24A. DATE FILED BY HEALTH DEPT.

DEC 14 1966

24B. NAME OF REGISTRAR

Robert E. Faldut

24C. FUNERAL DIRECTOR

ADDRESS

Loring Byers-8728 Liberty Rd. Randallstown



*[Handwritten signature]*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 12484				
BIRTH NO. 66 12484					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>ALLAN LOTTES</b>					2. DATE AND HOUR OF DEATH <b>12-10-66 1:55 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSP.</b>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALT.</b> D. STREET ADDRESS (If rural, give location) <b>3616 EITMILLER</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>11-29-06</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P. TELEPHONE</b>		11. BIRTHPLACE (State or foreign country) <b>BALT. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Louis Lottes</b>					14. MOTHER'S MAIDEN NAME <b>Anna Yoh</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>					16. SOCIAL SECURITY NO. <b>215-05-0892</b>		17. INFORMANT <b>Bertha Lottes-3616 Eitmiller Rd.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION 1 DAY</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>					INTERVAL BETWEEN ONSET AND DEATH <b>?</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <b>—</b>			
22. I certify that (1) (this hospital) attended the deceased from <b>12-9</b> 19 <b>66</b> to <b>12-10</b> 19 <b>66</b> , that (1) (we) lost saw the deceased alive on <b>12-10</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Alvin Schachter</b> M.D.								23B. DATE SIGNED <b>12-10-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALVIN SCHACHTER</b> M.D.					23D. ADDRESS <b>SINAI HOSP.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>12/14/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olive Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Randallstown, Md. 21133</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>DEC 14 1966</b>					25B. NAME OF REGISTRAR <b>Robert E. Tolson</b>		25C. FUNERAL DIRECTOR <b>Loring Byers-8728 Liberty Rd. Randallstown</b>		

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Handwritten text in the upper middle section, appearing to be a list or series of notes.

Handwritten text in the middle section, possibly a paragraph or a set of instructions.

Handwritten text in the lower middle section, continuing the notes or list.

Handwritten text at the bottom of the page, possibly a conclusion or signature.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12485		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 12485	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Roger Leland Hall		2. DATE AND HOUR OF DEATH Dec. 13, 1966 12: 17 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Pa. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Beaver	
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street		D. STREET ADDRESS (If rural, give location) 382- 4th Street		V-35	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/8/31	9. AGE (In years last birthday) 35	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Steward		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) NH	
13. FATHER'S NAME Clarence Hall		14. MOTHER'S MAIDEN NAME Muriel Greene		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 016-24-6544		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.)		(A) Right pleural effusion & atelectasis of right lung		Weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Bronchogenic carcinoma right lung with widespread metastases		Months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Sept. 29 19 66 to Dec. 13 19 66, that (1) (we) lost saw the deceased alive on Dec. 13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (d/d not) view the body after death.					
23A. SIGNATURE James M Weaver M.D.				23B. DATE SIGNED 12/13/66	
23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director M.D.				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12/14/1966		24C. NAME of CEMETERY or CREMATORY Beaver, Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1966		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Fisher	
ADDRESS Balto, Md.					



1  
P-623

66 12486

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 12486

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CLOVA

B.

PRESTON

2. DATE AND HOUR PRONOUNCED DEAD

December 10, 1966

11:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

320 E. 20-1/2 Street

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 320 E. 20-1/2 Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

April 26, 1908

9. AGE (in years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Ralph Pryor

14. MOTHER'S MAIDEN NAME

Frazier

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Gladys Jennings 2028 Kennedy Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease  
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/11/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12/13/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION (City, town, or county) (State)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm C March 928 E. North Ave.

WILLIAMSON

1918

1  
A-235

66 12487

BALTIMORE CITY HEALTH DEPARTMENT

66 12487

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LENA AUSTIN

2. DATE AND HOUR PRONOUNCED DEAD

12-11-66

12:00 Noon M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 2408 CALVERTON HEIGHTS AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2408 Calverton Heights Avenue 21216

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

6-9-1906

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Raleigh, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Lane H. Johnson 2408 Calverton Hgts

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-12-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-14-66

23C. NAME of CEMETERY or CREMATORY

Carver Mem. PK

23D. LOCATION

Laurel

(City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 14 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Mortimer Dyett F.H.

ADDRESS

1701 Laurens St.

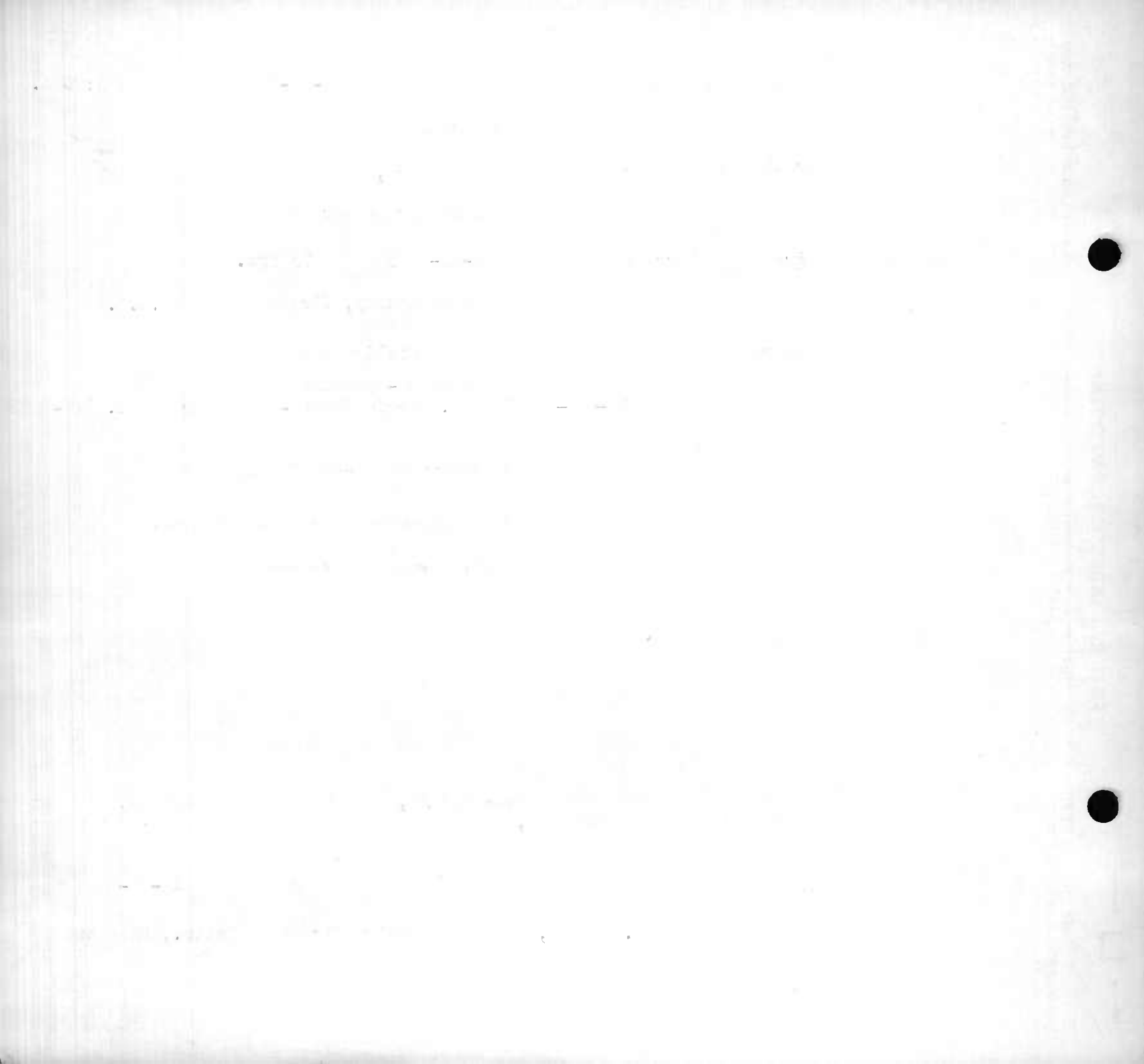
WILLIAM FORBES



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BIRTH NO. <b>66 12488</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12488</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Rosena Cauthorne</b>		2. DATE AND HOUR OF DEATH <b>12-10-66</b>   <b>3:00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore,</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore,</b> D. STREET ADDRESS (If rural, give location) <b>1838 Lorman Street</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>4-12-1893</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Essex County, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harvey Loudon</b>		14. MOTHER'S MAIDEN NAME <b>Estelle Loudon</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>230-03-6007</b>		17. INFORMANT <b>Kenneth - Husband</b> <b>Mrs. Carrie Jones - daughter</b> ADDRESS <b>SAME</b> Tele. <b>947-0582</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>① Acute myocardial infarction</b> DUE TO (B) <b>② Coronary artery thrombosis</b> DUE TO (C) <b>③ Pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 28, 1966</b> to <b>December 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 10, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Amigore</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>12-10-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Amigore</b>				23D. ADDRESS <b>1514 Division Street Balto., Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-13-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION <b>Balto.</b>		24E. STATE <b>Md.</b>		24F. COUNTY <b>Balto.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1966</b>		25B. NAME OF REGISTRAR <b>Dr. E. J. F. H.</b>		25C. FUNERAL DIRECTOR <b>1701 Laurens</b>	



66 12489

BALTIMORE CITY HEALTH DEPARTMENT

66 12489

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

(MCGHEE)

THELMA LEWIS WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

12-11-66

8:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

128 Carver Road

5. SEX

FEMALE

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Dec 27, 1920

9. AGE (in years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Buchanan, West. VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Scott McGee

14. MOTHER'S MAIDEN NAME

Jennie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Donnie Williams 2027 Clifwood

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Fatty alteration of liver

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Partial

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-12-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-16-66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

A.A. Co.

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 14 1966

M. J. S. Tolson

Morton E. Dyett F.H.

1701 Laurens

00711-6  
005-2

100

Subject

100

100

100

100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		66 12490		66 12490	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
RAYMOND BELT CORNELIUS			11 25 PM 12/12/66 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
38 UNIV. HOSPITAL			MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			713 MCKEWIN AVE.		
5. SEX	6. RACE	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
M	W		6/22/87	79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
RETIRED CONDUCTOR PA. RR			BALTIMORE, Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
WALTER CORNELIUS			SARAH JANE WILLIAMS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					MRS. BESSIE M. CORNELIUS (SAME)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) congenital hereditary splenocytosis		Life long
ANTECEDENT CAUSES			(B) duodenal ulcer		1957 →
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) cirrhosis of the liver		?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
hip fracture (R intertrochanteric)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
12/21/66		splenectomy		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/27/66 19 to 12/12/66 19, that (he) (we) last saw the deceased alive on 12/12/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Anne C. Colston				12/12/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Anne C. Colston				University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/15/1966		Evangelical Lutheran Ch.	
				Shrewsbury, Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 14 1966		R. E. E. Jelena		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

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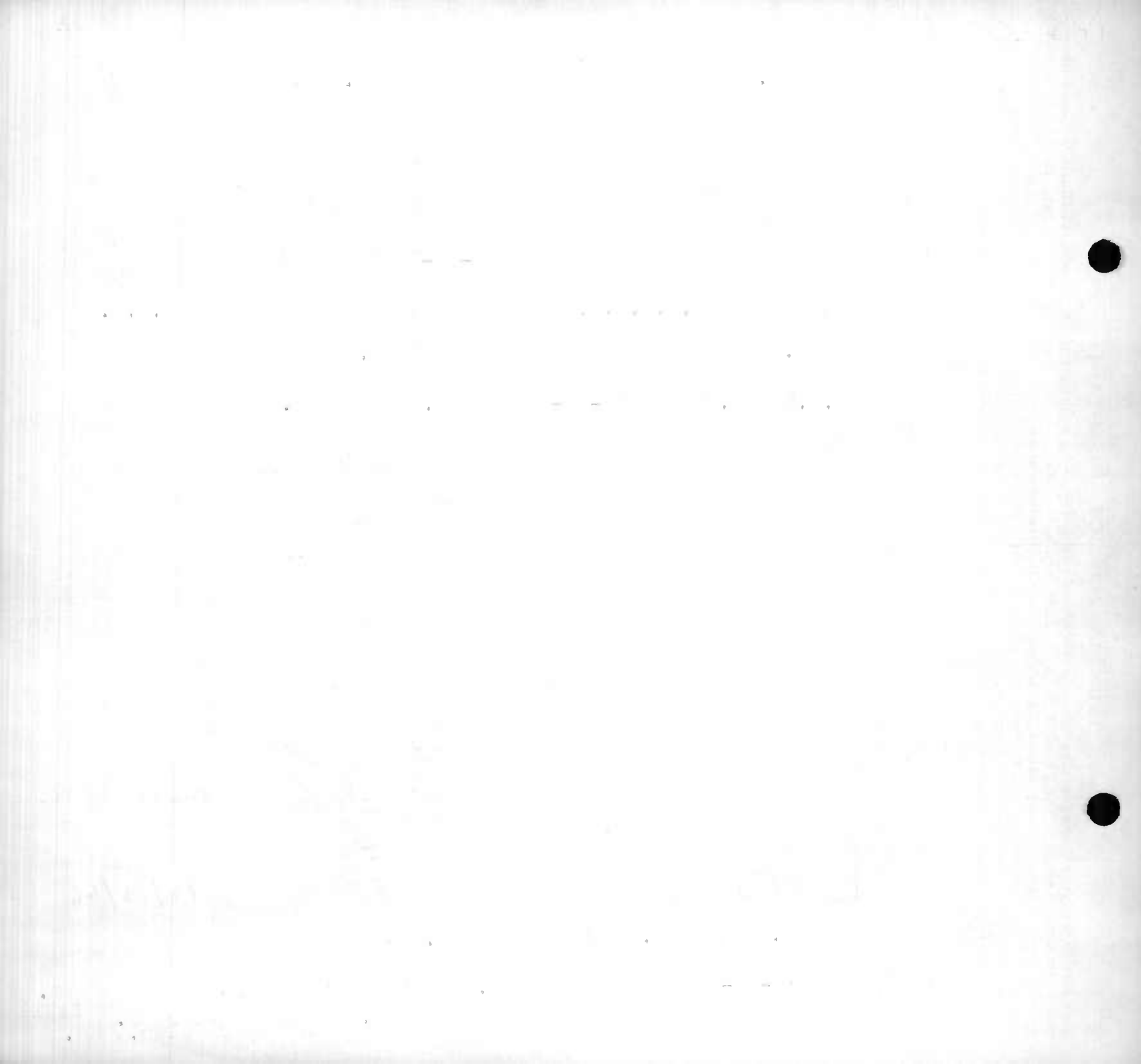
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12491	
BIRTH NO. 66 12491		M.E. CASE NO. 66 12491		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Dr. Kenneth Fuller Maxcy			2. DATE AND HOUR OF DEATH Dec. 12, 1966 10 42 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 Upland Road			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4 Upland Road		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-27-1889	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10B. KIND OF BUSINESS OR INDUSTRY U.S.P.H.S.	11. BIRTHPLACE (State or foreign country) Saco, Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frederick E. Maxcy			14. MOTHER'S MAIDEN NAME Estelle A. Gilpatric		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I & W.W.II		16. SOCIAL SECURITY NO. 579-36-9400	17. INFORMANT Mrs. Gertrud H. Maxcy		ADDRESS Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 350 X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Parkinson's Disease</u> DUE TO (B) <u>Arteriosclerosis</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Benign Prostatic Hypertrophy</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1950 to Dec 12 1966, that (I) (we) lost saw the deceased alive on Dec 12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Walter B. Buck</u>				23B. DATE SIGNED 12/13/66	
23C. PHYSICIAN'S NAME (Type) Dr. Walter B. Buck		23D. ADDRESS 18 E. Eager Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-14-66		24C. NAME OF CEMETERY or CREMATORY Arlington Nat'l. Cemetery Arlington, Va.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. DEC 14 1966			
25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md.			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 12492</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>66 12492</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Knight William R</u>			<b>2. DATE AND HOUR OF DEATH</b> <u>12-12-66</u>   <u>10 40</u> <small>P.M.</small>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hosp.</u> (If not in hospital or institution, give street address or location)			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____  C. CITY OR TOWN <u>Balto.</u> (If outside city limits, write RURAL and give township)  D. STREET ADDRESS <u>2452 Frederick Ave.</u> (If rural, give location) <u>21223</u>		
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED</b> (specify) <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>JAN. 22, 1892</u>	<b>9. AGE</b> (In years last birthday) <u>74</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED BARTENDER</u>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>TAVERNS</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			<b>13. FATHER'S NAME</b> <u>William H. KNIGHT</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>Florence M. Rhoades</u>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
<b>16. SOCIAL SECURITY NO.</b> <u>220-07-0195</u>			<b>17. INFORMANT</b> ADDRESS <u>MRS. AGNES KNIGHT 3231 LAWNVIEW AVE 21213</u>		
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>1913 I METASTATIC DISEASE MONTHS</u>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
<b>19A. DATE OF OPERATION</b> <u>12/13</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>November 22, 1966</u> <b>to</b> <u>December 12, 1966</u> , <b>that (I) (we) lost</b> <u>the deceased</u> <b>on</b> <u>December 12, 1966</u> <b>and that in (my) (our) opinion death occurred on the date</b> <u>and hour</u> <b>and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>DAE HUN KIM</u> M.D.				<b>23B. DATE SIGNED</b> <u>1</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>DAE HUN KIM</u> M.D.				<b>23D. ADDRESS</b>	
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>24B. DATE</b> <u>12/16/66</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>LORRAINE PARK Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>BALTIMORE Co. Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 14 1966</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor</u>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <u>WM. COOK - BROOKS 1217 ST. PAUL ST.</u>			

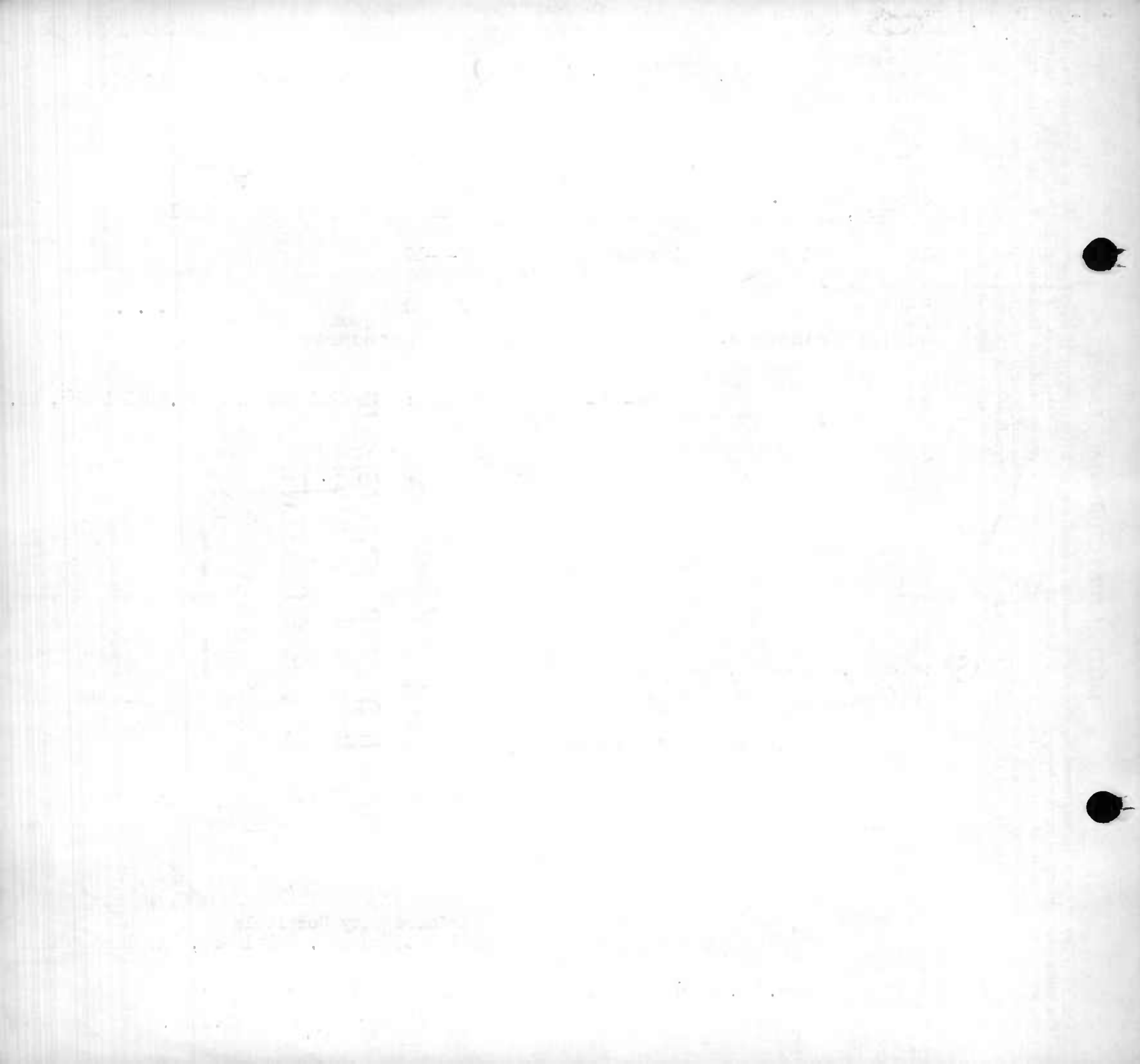
1/17/67 - Squamous cell Ca.

of jaw & metastases  
to lung - Information from Ben Lee, Hosp.  
Letter in Document File - Div. of Biostatistics  
American Bd. of Surg. &

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

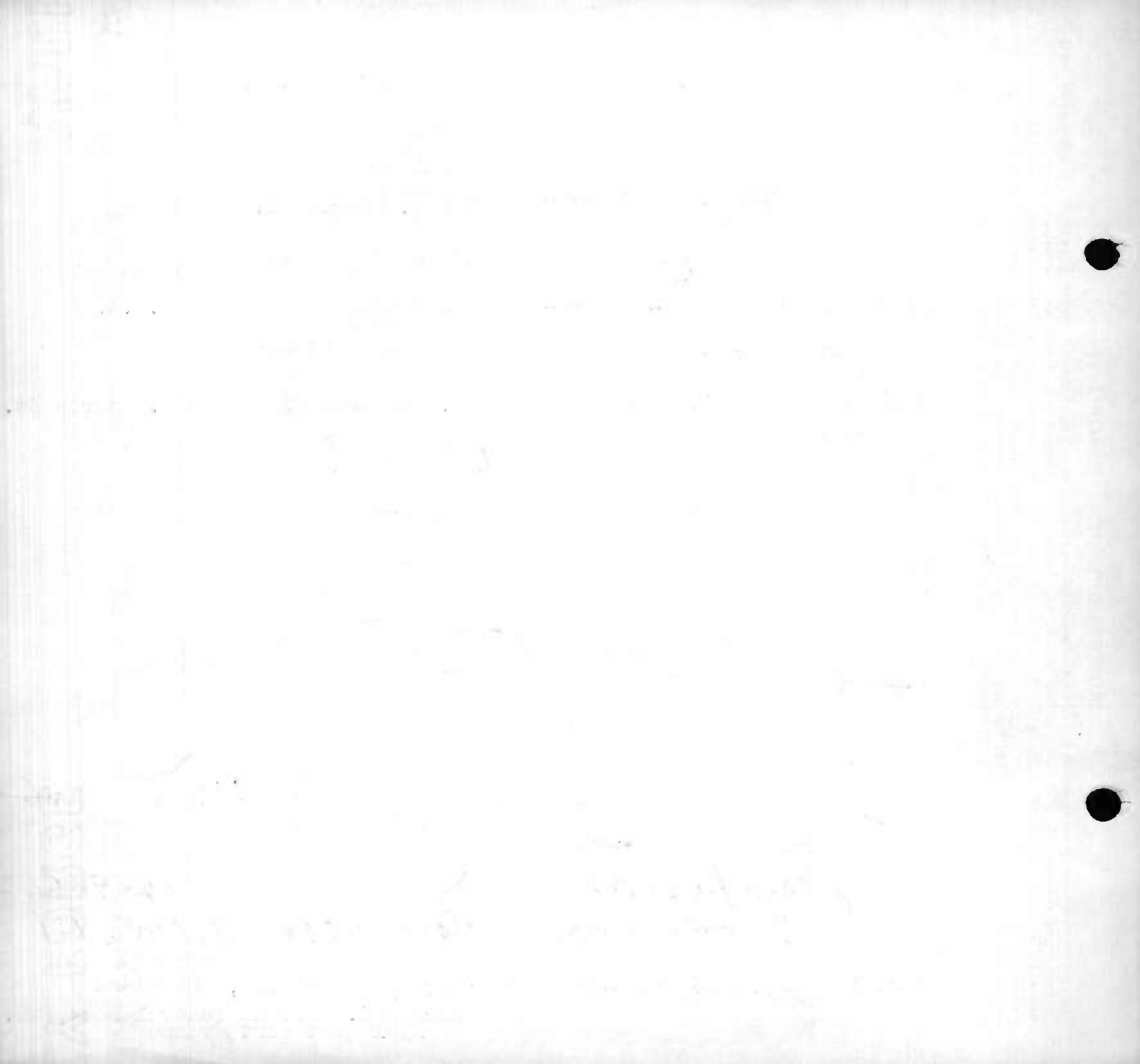
BIRTH NO. <b>66 12493</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 12493</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FREDERICK G. FELDMANN</b>		2. DATE AND HOUR OF DEATH <b>12-10-66 12 Noon M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>1940 Eastern Ave. Baltimore, Maryland # 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	
8. DATE OF BIRTH <b>3-8-10</b>		9. AGE (In years last birthday) <b>56</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Rudolph Feldman n.</b>	
14. MOTHER'S MAIDEN NAME <b>Pauline Bohrer</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-09-6526</b>	
17. INFORMANT <b>Records: BCH 4940 Eastern Ave. Baltimore, Md.</b>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Aspiration Pneumonia and Cerebral Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		20. CAUSE OF DEATH (A) <b>Aspiration Pneumonia and Cerebral Vascular Disease</b> (B) <b>Carcinoma Right Testis Prostate</b> (C) <b>Peritonitis</b>		21. INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>Multiple Procedures</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostatectomy, Bilateral Nephrectomy, Distal Bowel Resection</b> 19C. DATE OF OPERATION <b>12-7-66</b> 19D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 20A. AUTOPSY? (Yes or No) <b>YES</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> 20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Baltimore City Hospitals</b> 20D. HOW DID INJURY OCCUR? <b>4940 Eastern Ave. Baltimore, Maryland #21224</b> 20E. DATE OF INJURY (Month) (Day) (Year) (Hour) <b>12-10-66</b> 20F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 20G. DATE OF INJURY (Month) (Day) (Year) (Hour) <b>12-10-66</b> 20H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 20I. DATE OF INJURY (Month) (Day) (Year) (Hour) <b>12-10-66</b> 20J. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
23. I certify that (I) (this hospital) attended the deceased from <b>11-23-1966</b> to <b>12-10-1966</b> , that (I) (we) last saw the deceased alive on <b>12-10-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		24. SIGNATURE <b>[Signature]</b>		25. DATE SIGNED <b>12-10-66</b>	
26. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		27. ADDRESS <b>Baltimore City Hospitals</b>		28. ADDRESS <b>4940 Eastern Ave. Baltimore, Maryland #21224</b>	
29. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		30. DATE <b>Dec. 14, 1966</b>		31. NAME OF CEMETERY or CREMATORY <b>Baltimore Cem.</b>	
32. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1966</b>		33. NAME OF REGISTRAR <b>R. E. [Signature]</b>		34. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>	
35. ADDRESS <b>Baltimore Md.</b>		36. ADDRESS <b>Baltimore Md.</b>		37. ADDRESS <b>Baltimore Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 12494</span>	
BIRTH NO. <span style="float: right;">66 12494</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="float: right;">Thomas L. Flynn</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">December 8, 1966</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 2em;">36</span> Franklin Square Hospital		A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">19-04</span>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">Baltimore</span>			
		D. STREET ADDRESS (If rural, give location) <span style="float: right;">525 S. Monroe St. #21223</span>			
5. SEX <span style="float: right;">M</span>	6. RACE <span style="float: right;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="float: right;">Married</span>	8. DATE OF BIRTH <span style="float: right;">4/2/1895</span>	9. AGE (In years last birthday) <span style="float: right;">71</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Tavern Owner</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">-----</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>		13. FATHER'S NAME <span style="float: right;">John Flynn</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Mary Gibbons</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">Yes 4/24/18 To 7/12/19</span>		16. SOCIAL SECURITY NO. <span style="float: right;">217-07-9381</span>		17. INFORMANT <span style="float: right;">Mrs. Margaret Flynn 525 S. Monroe St.</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 2em;">ASCVD</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">7,</span>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="float: right;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">March 19 66</span> to <span style="float: right;">Dec 8 19 66</span> that (I) <span style="float: right;">last</span> saw the deceased alive on <span style="float: right;">Dec 6 19 66</span> and that in (my) <span style="float: right;">last</span> opinion death occurred on the date and hour and from the causes stated above. (I) <span style="float: right;">did not</span> (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Earl Pass M.D.</span>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="float: right;">12-9-66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">I. EARL PASS</span>		M.D.		23D. ADDRESS <span style="font-size: 1.5em;">4001 Wilshire Ave Bkto Md</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">12/12/66</span>		24C. NAME of CEMETERY or CREMATORY <span style="float: right;">New Cathedral Cemetery</span>	
				24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore, Maryland</span>	
25A. DATE REC'D. BY HEALTH DEPT. <span style="font-size: 1.5em;">DEC 14 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">R. E. Flynn</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Charles L. Stevens</span>	
				ADDRESS <span style="font-size: 1.5em;">1501 East Fort Avenue</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12495	
BIRTH NO. 66 12495		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>John Pradich</u>		2. DATE AND HOUR OF DEATH <u>12/7/66 - 7:30 p.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Century Home, Inc. 102 N. Paca St</u>		A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>24-01</u>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. <u>MARRIED</u> , NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Riveter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Maryland Ship Building and Drydock</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Andrew Pradich</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Pradich</u>		12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-9111</u>		17. INFORMANT ADDRESS <u>Mrs. Rosalie R. Pradich 1442 Richardson St.</u>	
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <u>Cardio-Respiratory Failure</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Diabetes Mellitus</u>			
		(C) <u>Arteriosclerotic CUN</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> 19 <u>66</u> to <u>Dec 7</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Willard Applefeld</u> M.D.				23B. DATE SIGNED <u>12/8/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Willard Applefeld</u>				23D. ADDRESS <u>5901 Park Heights Rd.</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/10/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Charles L. Stevens Funeral Home, Inc.</u> ADDRESS <u>1501 E. Fort Avenue</u>	

No. \_\_\_\_\_  
 212-10-2111 The Kessler R. Product four times  
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Butler's Refractory and Heat-Resisting  
 Charles L. Stevens  
 1701 S. Fort Avenue

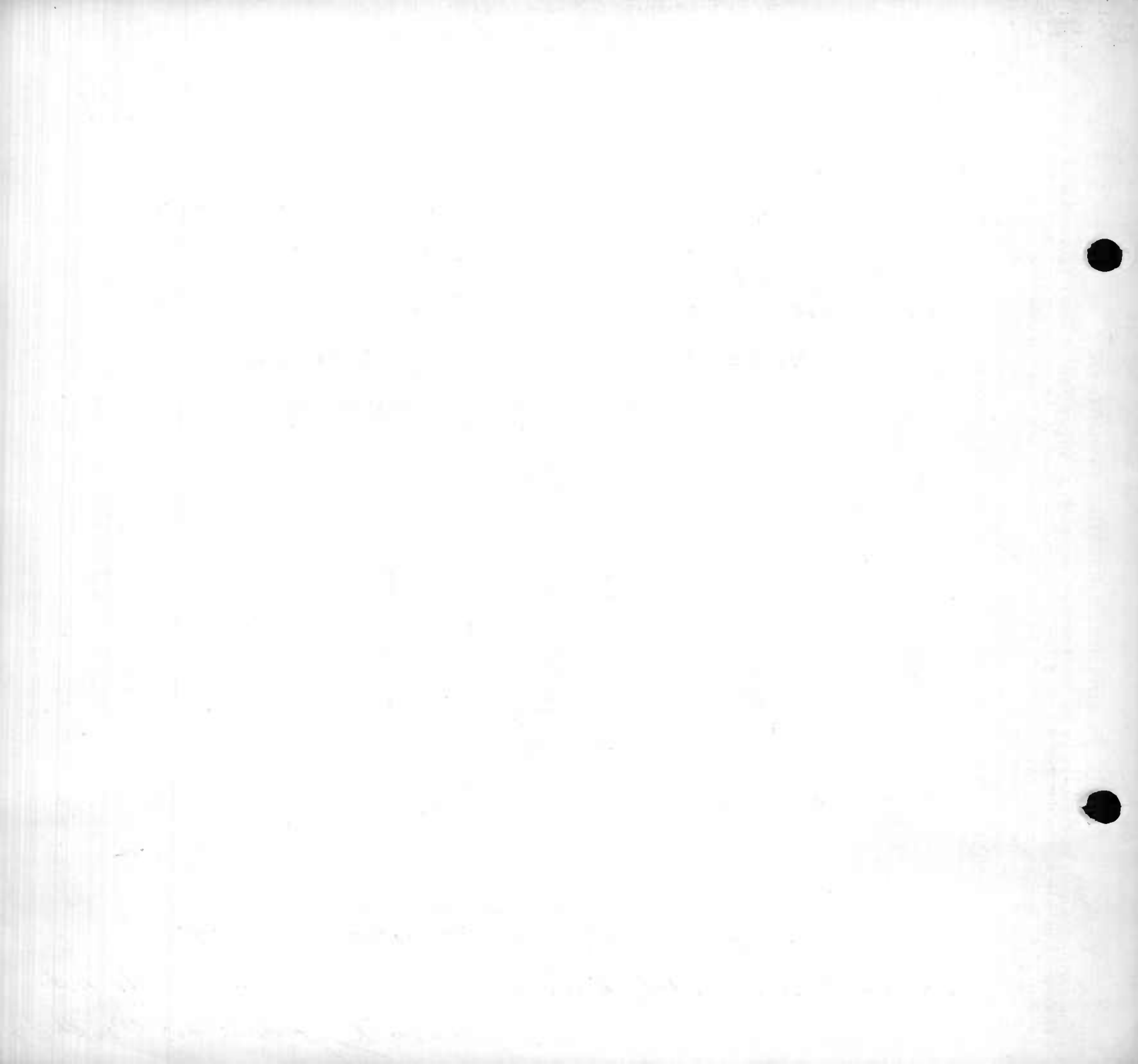


48-06-170  
EGL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 12496		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 12496	
1. NAME OF DECEASED (Type or Print) <i>Rose Ciociolo</i>				2. DATE AND HOUR OF DEATH <i>12-12-66 10:00 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>BALTIMORE CITY HOSPITALS 4040 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1-02</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>3131 EASTERN AVENUE 21224</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>5-25-92</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
13. FATHER'S NAME <i>CHARLES VALENTI</i>			14. MOTHER'S MAIDEN NAME <i>AGNES CIRIAGO</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>24-32-0701</i>		17. INFORMANT <i>BCH</i> ADDRESS <i>RECORDS: 4940 EASTERN AVENUE 21224</i>	
18. <i>332X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>Hypertension</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i> <i>7 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(1)</i> (this hospital) attended the deceased from <i>11-6</i> 19 <i>66</i> to <i>12-12</i> 19 <i>66</i> , that <i>(1)</i> (we) last saw the deceased alive on <i>12-12</i> 19 <i>66</i> and that in <i>(our)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(1)</i> (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Richard L. Bishop</i> M.D.				23B. DATE SIGNED <i>12-12-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>RICHARD L. BISHOP</i>		23D. ADDRESS M.D. <i>4940 Eastern Avenue 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>Dec 15, 1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem Baltimore Md.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Joseph J. Zomard</i>			
25D. ADDRESS <i>263 S Con Rhus St</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 12497				
BIRTH NO. 66 12497									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) (Sister) M. Perpetua Criolla					2. DATE AND HOUR OF DEATH December 9th. 1966   1:30 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Saint Agnes Hospital 40 Caton & Wilkens Aves 21229					A. STATE Maryland B. COUNTY Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 701 Gun Road. "27 (Oblate Sisters)				
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 3/16/81	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NUN			10B. KIND OF BUSINESS OR INDUSTRY Oblate Sisters		11. BIRTHPLACE (State or foreign country) Cienfuegos Cuba		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Rafina Criolla				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mother M. Lora			ADDRESS 701 Gun Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Benchopneumonia					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Remain					M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12/9/66	
23C. PHYSICIAN'S NAME (Type) Dr. E. Marin					23D. ADDRESS M.D. St. Agnes Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 13/66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemo		24D. LOCATION (City, town, or county) (State) Bald. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1966		25B. NAME OF REGISTRAR J. E. J.			25C. FUNERAL DIRECTOR Joseph P. Clicker 11297, Annapolis				

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 12498					CERTIFICATE OF DEATH		Registered No. 66 12498		
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <i>McJohnson Pitt, Irene</i>				
2. DATE AND HOUR OF DEATH <i>12/11/66 3:30 A.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
THE JOHNS HOPKINS HOSPITAL					MARYLAND				
33					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE				
D. STREET ADDRESS (If rural, give location)					1610 E. BIDDLE ST.				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
FEMALE	NEGRO	MARRIED	5-2-04	62					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife					Washington D.C.				
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
Richard Bell			SARAH BELL						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
					Benjamin Pitt		1610 E. Biddle		
18. <i>4-3-2X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO			<i>Purulent pericarditis</i>	
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
O									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <i>11/25</i> 19 <i>66</i> to <i>12/11</i> 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>12/11</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>David S. Fedson</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-11-66</i>		
23C. PHYSICIAN'S NAME (Type) <i>DAVID S. FEDSON</i> M.D.					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		<i>Dec 15/66</i>		<i>Arbutus Mem. Park</i>		<i>Arbutus Md.</i>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<i>DEC 14 1966</i>		<i>Robert E. Jackson</i>		<i>John T. Erickson</i>		<i>1129 N</i>			

Theresa Bell

Theresa Bell

Theresa Bell

Theresa Bell

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 12499	
BIRTH NO. 66 12499		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FRANCIS Frank J. Regan</b>		2. DATE AND HOUR OF DEATH <b>Dec. 13, 1966 6.00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21212</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>703 Murdock Rd.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8/26/91</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas C. Regan</b>		14. MOTHER'S MAIDEN NAME <b>Annie L. Collins</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-22-88303</b>		17. INFORMANT <b>Pauline Regan (wife)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I MYOCARDIAL RUPTURE, CARDIAC TAMPONADE</b>		(A) DUE TO <b>MYOCARDIAL INFARCTION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>MINS 70</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ANTERIOR HEART DISEASE</b>		(B) DUE TO <b>ANTERIOR HEART DISEASE</b>		<b>YES</b>	
(C) DUE TO <b>DISEASE</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 6 1966</b> to <b>Dec. 13 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 13 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Michael Gould</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/13/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. Michael Gould</b>		M.D. 23D. ADDRESS <b>Md. General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/16/66.</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Joseph's Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Texas, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1966</b>		25B. NAME OF REGISTRAR <b>DEC 14 1966</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25D. ADDRESS			

Memorandum

2nd March 1941

8/12/41

W. H. C. C.

U.S.A.

Memorandum

W. H. C. C.

James C. Rogers

James C. Rogers

2nd

James C. Rogers  
Central

Dec 12

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Dec 12

W. H. C. C.

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12/13/41



BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. **66 12500**

BIRTH NO. **66 12500**  
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>LEONARD J. TERZANO</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>December 13, 1966 9:16 A</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4611 Valley View Avenue</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore #6 26-02</b> D. STREET ADDRESS (If rural, give location) <b>4611 Valley View Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 5, 1899.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Tailor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	9. AGE (In years last birthday) <b>67</b>
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Terzano</b>		14. MOTHER'S MAIDEN NAME <b>Carmela Perrella</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-07-9109</b>	17. INFORMANT ADDRESS <b>Mrs. Anna P. Terzano (Same)</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive and Arteriosclerotic Heart Disease.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH			
II			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>12/13/66</b>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>12/17/66.</b>	23C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>
23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Feiberg</b>	24C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>

